

00-04516

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86 11437
REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		7b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		MONTH DAY YEAR		10:06 ^a	
RUSSELL S. ANDERSON		April 21, 1986			
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR	
Male	White	MONTH DAY YEAR	77 YRS	MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH		
Massachusetts	U. S.		Cecil County MD.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
Perry Point, Md.	VA Medical Center		Photographer		Fed. Gov't
13a. STATE		13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	
Md.	Harford	Bel Air	YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME			
FIRST MIDDLE LAST		FIRST MIDDLE LAST			
Martin Anderson		Emma Alquist			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS		
Yes		WWII	Mrs. Diane Anderson - Same as #13		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY:					
IMMEDIATE CAUSE (a) Cardio-pulmonary arrest					
DUE TO, OR AS A CONSEQUENCE OF					
(b) Probable pneumonia & congestive heart failure					
DUE TO, OR AS A CONSEQUENCE OF					
(c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a					
Senile dementia of the Alzheimer's type					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
		YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
	P.M. 19				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from January 3, 1985, to April 21, 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated					
22b. SIGNATURE					
DEGREE					
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>					
22c. DATE SIGNED					
4-21-86					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)					
JOHN LONERGAN, M.D.					
22e. ADDRESS					
VA Medical Center, Perry Point, Md.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN COUNTY STATE		
Removal	4-21-86				
24. FUNERAL DIRECTOR			25a. DATE REC'D. BY REGISTRAR		
NAME ADDRESS			25b. REGISTRAR'S SIGNATURE		
Maryland Board of Maryland Balto., Md.			APR 24 1986		

0-04344

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8 6 1 1 4 3 8
REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
William J. Anderson				April 15, 1986		3:40A M	
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS	
Male	White	Aug. 10, 1905		80 YRS			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
Minnesota	USA			Cecil MD.			
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
Perry Point	VA Medical Center		Tool Disp.		APG		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
Maryland		Harford		Abingdon		13e. STREET ADDRESS / ZIP CODE 1011 Otter Point Rd. 21009	
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST					
William August Anderson		Theresa Leibel					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
Yes 8/22/42-9/13/45		474 09 1037		Janet L. Anderson 1011 Otter Point Rd 21009			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>no</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (X) (this hospital) attended the deceased from <u>March 4</u> 19 <u>86</u> to <u>April 15</u> 19 <u>86</u> , that (X) (we) last saw the deceased alive on <u>April 15</u> 19 <u>86</u> , and that in (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (not) view the body after death.							
22b. SIGNATURE <i>Christopher M. Berchelmann, M.D.</i>				DEGREE M.D.		22c. DATE SIGNED 4/15/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS			
Christopher M. Berchelmann, M.D.				VA Medical Center, Perry Point, MD 21902			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
Cremation		4/17/86		RA Ferris & Company		West Chester Chester Pa.	
24. FUNERAL DIRECTOR <i>Patterson Funeral Home</i>				ADDRESS Perryville, Md		25a. DATE RECD. BY REGISTRAR APR 22 1986	
						25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

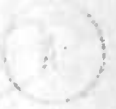
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

RECEIVED
FEDERAL BUREAU OF INVESTIGATION
U.S. DEPARTMENT OF JUSTICE

RECEIVED
FEDERAL BUREAU OF INVESTIGATION
U.S. DEPARTMENT OF JUSTICE



100-344184

00-03302

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death and may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove the top papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, entombment, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 6 1 1 4 3 9 REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) <u>Hazel H. Arches</u>						2a. DATE OF DEATH MONTH DAY YEAR <u>4/8/86</u>		2b. HOUR <u>10:10</u> A.M.			
3 SEX <u>Female</u>		4 RACE <u>White</u>		5. DATE OF BIRTH MONTH DAY YEAR <u>Oct. 3, 1902</u>		6 AGE (IN YEARS LAST BIRTHDAY) <u>83</u> YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. <u>10/10</u>			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Liberty, N. Y.</u>		7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <u>Cecil Co.</u> MD.					
10 CITY OR TOWN OF DEATH <u>EIKTON</u>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Union Hospital</u>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>housewife</u>		12b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE <u>Md.</u>		13b. COUNTY <u>Cecil</u>		13c. CITY OR TOWN <u>Pleasant Hill</u>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <u>R. D. #1 21921</u>			
14 FATHER'S NAME FIRST MIDDLE LAST <u>Arthur Brown</u>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <u>Ann</u>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>no</u>				16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <u>Baltimore, Md.</u> <u>Mary Williams 905 C Ashbridge Dr.</u>					
18 CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>RESPIRATORY ARREST</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u>			
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>EXAGGERATION OF COPD</u>								DAYS			
DUE TO, OR AS A CONSEQUENCE OF (c) <u>ASPIRATION SPONTANEOUS PNEUMOTHORAX</u>								DAY			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <u>FEDING BY GASTROSTOMY TUBE CHRONIC SUBARACHNOID</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <u>P.M. 19</u>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <u>721 BRIDGE ST. EIKTON MD 21921</u>							
22a. I certify that (1) this hospital attended the deceased from <u>3/13</u> , 19 <u>85</u> , to <u>4/8</u> , 19 <u>86</u> , that (1) (we) lost saw the deceased alive on <u>4/8</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>[Signature]</u>				DEGREE <u>MD</u> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <u>4/8/86</u>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>LINWOOD LINDSAY MD</u>				22e. ADDRESS <u>721 BRIDGE ST. EIKTON MD 21921</u>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		23b. DATE <u>4-11-86</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Gilpin Man. Mem. Pk.</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>Eikton Cecil Md.</u>					
24. FUNERAL DIRECTOR NAME ADDRESS <u>Gee Funeral Home, EIKTON, MD</u>				25a. DATE REC'D. BY REGISTRAR <u>APR 14 1986</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>					

BP



00-05311

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 1 1 4 4 0

REG. NO.

FOR
1- STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
CLARA J. ATWOOD					APRIL 22, 1986		A.M.	
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
FEMALE	WHITE	JUNE 15, 1895			90 YRS.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			
MARYLAND	U.S.A.				CECIL COUNTY MD.			
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
ELKTON	UNION HOSPITAL OF CECIL COUNTY			HOMEMAKER				
13a. STATE		13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE			
MARYLAND		CECIL	ELKTON		406 NORTH ST. 21921			
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST			ADDRESS			
GEORGE F. JUERGENS		JULIA PRYOR			Carneys Pt. N.J. 08069			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT				
NO		716 01 9115		EMMA GOLT, Box 265 , Cedar Crest Manor,				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio Respiratory Arrest</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DUE TO, OR AS A CONSEQUENCE OF <u>Pulmonary Edema & Pneumonia</u>								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF <u>Cerebral Vascular Accident</u>								
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u></u>								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
21g. I certify that (I) (this hospital) attended the deceased from <u>July 11, 1953</u> to <u>Apr 22, 1986</u> , that (I) (we) last saw the deceased alive on <u>4/22/86</u> and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If you did not see the body after death, so state.)								
22a. SIGNATURE					DEGREE	22c. DATE SIGNED		
22b. PHYSICIAN'S NAME (TYPE OR PRINT)					ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	4-24-86		
JOSEPH G. LANZI, M.D.					22e. ADDRESS			
					721 BRIDGE STREET, ELKTON, MD. 21921			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE		
BURIAL		4/25/86		IMMACULATE CONCEPTION		ELKTON, MARYLAND CECIL MD.		
24. FUNERAL DIRECTOR					25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
HICKS HOME FOR FUNERALS, ELKTON, MD					MAY 1 1986			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, and may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORT NOTE: If item 21 is marked as item 18 above any injury, or other traumatic event, the medical examiner must file the required evidence.

BP

4025 COTTON 4855

WINTER 1911

WINTER 1911



11653-00

00-02996

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) THOMAS B BENNETT			2a. DATE OF DEATH MONTH DAY YEAR APRIL 6, 1986		2b. HOUR 7:25A M
3. SEX Male	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR April 24, 1900		6. AGE (IN YEARS LAST BIRTHDAY) 85 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) North Carolina	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Cecil MD.	
10. CITY OR TOWN OF DEATH PERRY POINT, MD	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) VA MEDICAL CENTER		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Special Police		12b. BUSINESS OR INDUSTRY INTERNAL REVENUE
13a. STATE Virginia	13b. COUNTY N/A	13c. CITY OR TOWN Arlington	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 208 N. Wayne Street 22201	
14. FATHER'S NAME FIRST MIDDLE LAST E.P. Bennett		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Zelphia Morrison			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) W.W.II 577-22-0432		17. INFORMANT ADDRESS Address Same as No# 13.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ARREST					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LOST.					
DUE TO, OR AS A CONSEQUENCE OF (b) EXTENSIVE PNEUMONIA DUE TO, OR AS A CONSEQUENCE OF (c) HYPERTENSIVE ARTERIOSCLEROTIC HEART DISEASE					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from AUGUST 15 , 19 85 , to APRIL 6 , 19 86 , that (x) (we) last saw the deceased alive on APRIL 6 , 19 86 , and that in (x) (our) opinion death occurred on the date and hour and from the causes stated above (x) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>Glady's Ocejo</i>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>	22c. DATE SIGNED 4/6/86
22d. PHYSICIAN'S NAME (TYPE OR PRINT) GLADYS OCEJO, M.D.			22e. ADDRESS VA MEDICAL CENTER, PERRY POINT, MD.		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE Apr. 9, 1986	23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Suitland P.G. Maryland	
24. FUNERAL DIRECTOR NAME ADDRESS GASCH'S FUNERAL HOME, HYATTSVILLE, MD.			25a. DATE REC'D. BY REGISTRAR APR 9 1986		
			25b. REGISTRAR'S SIGNATURE <i>J. H. Davidson</i>		

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or transport.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 60M 7/84
(VRA 15, 4)

APR 9 1986

00-02000

REC-115

NOV 19 1986

RECEIVED
NOV 19 1986

NOV 19 1986

NOV 19 1986

NOV 19 1986



NOV 19 1986

NOV 19 1986

00-03091

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed and filed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies of pages 1 and 2 and file them with the funeral director. Page 4 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition of the body. **IMPORTANT:** If item 21 is marked at item 11 shows any injury, or other traumatic event, the medical examiner must be notified of this.DHMH - 16 50M 1/76
(VR A 15 (4))

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1. FOR STATE REGISTRAR										7 6 1 1 4 4 2	
1 DECEASED NAME (TYPE OR PRINT)					2a. DATE OF DEATH					2b. HOUR	
PHYLLIS BIDGOOD					4 1 86					6:10 P M	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR		8. IF UNDER 24 HRS.	
Female		White		MONTH 9 DAY 4 YEAR 02		83 YRS.		MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Ohio		U.S.				Cecil County MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Elkton		Laurelwood Nurs. Ctr.				Homemaker					
13a. STATE 13b. COUNTY 13c. CITY OR TOWN 13d. INSIDE CITY LIMITS? 13e. STREET ADDRESS											
Md. Cecil Earleville YES <input type="checkbox"/> NO <input type="checkbox"/> 195 Hazlewood Dr. 21919											
14. FATHER'S NAME (FIRST MIDDLE LAST)					15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST)						
James McDonald					Matilda Allen						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)					16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS				
No					212-58-0208		Ms. Betty J. Zang Same as #13				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ovarian Carcinomatosis with mets.</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 years</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (the physician) attended the deceased from <u>June</u> , 19 <u>85</u> , to <u>Apr 1</u> , 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>Apr 1</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Wallace Obenshain</u> M.D.					22c. DATE SIGNED <u># Apr 86</u>						
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Wallace Obenshain, M.D.					22e. ADDRESS Cecilton, Md.						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal			23b. DATE 4-1-86		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION CITY OR TOWN COUNTY STATE			
24. FUNERAL DIRECTOR NAME Anatomy Board					25a. DATE REC'D. BY REGISTRAR APR 10 1986		25b. REGISTRAR'S SIGNATURE <u>John Davidson-Randall</u>				

BP



00-044131-

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6

1 1 4 4 3

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) MARION		FIRST H.		MIDDLE BOGGS		LAST		20. DATE OF DEATH MONTH 4 DAY 15 YEAR 86		2b. HOUR 14.55PM	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH 5 DAY 16 YEAR 1911		6. AGE (IN YEARS LAST BIRTHDAY) 74 yrs -		IF UNDER 1 YEAR MONTHS 0 DAYS 0		IF UNDER 24 HRS. HOURS 0 MIN. 0	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Cecil MD.					
10. CITY OR TOWN OF DEATH ELKTON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Union Hospital						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Material Handler		12b. KIND OF BUSINESS OR INDUSTRY Chry. Corp.	
13a. STATE Maryland				13b. COUNTY Cecil		13c. CITY OR TOWN Elkton		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 1551 Augustine Herman Hwy. 21921	
14. FATHER'S NAME FIRST Daniel MIDDLE J. LAST Boggs				15. MOTHER'S MAIDEN NAME FIRST Virginia MIDDLE - LAST Sowers							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WWI		17. INFORMANT Mrs. Anna A. Boggs, Elkton, Md. 21921							

18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intractable Congestive Heart failure		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DUE TO, OR AS A CONSEQUENCE OF (b) Coronary Arteries Disease			
DUE TO, OR AS A CONSEQUENCE OF (c) Previous Myocardial Infarction			

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 5/16/80 , 19____, to 4/15/86 , 19____, that (I) (we) last saw the deceased alive on 4/15/86 , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Jayantilal K. Patel MD		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 4/15/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JAYANTILAL K. PATEL MD		22e. ADDRESS 1235 Singler Ave - Elkton MD 21921					

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 4-19-86		23c. NAME OF CEMETERY OR CREMATORY Gilpin Manor Memorial Park		23d. LOCATION CITY OR TOWN Elkton COUNTY Maryland STATE 21921	
24. FUNERAL DIRECTOR NAME Ralph E. Hicks ADDRESS HICKS HOME FOR FUNERALS, ELKTON, MD. 21921				25a. DATE REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE APR 23 1986			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

00-04025

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE MARYLAND 21201

BP

DHMM - 16 50M 7/77
(VR A15 (4))

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 8611444																			
1. FOR STATE REGISTRAR						2a. DATE OF DEATH MONTH DAY YEAR 4-14-86						2b. HOUR 12:55 PM																	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Boyer, Celestia M.						3. SEX F						4. RACE C		5. DATE OF BIRTH MONTH DAY YEAR 8-3-12		6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS		7. IF UNDER 24 HRS. HOURS MIN.									
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VT.						7b. CITIZEN OF WHAT COUNTRY? U.S.A.						8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>						9. BALTIMORE CITY OR COUNTY OF DEATH Cecil MD.											
10. CITY OR TOWN OF DEATH EIKTON						11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) UNION Hospital						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Sales Clerk						12b. KIND OF BUSINESS OR INDUSTRY Retail											
13a. STATE MD						13b. COUNTY Cecil						13c. CITY OR TOWN EIKTON						13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						13e. STREET ADDRESS 1076 W. Putnam Hwy. 21921					
14. FATHER'S NAME FIRST MIDDLE LAST George Besette						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Celestia Lasson						16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO						16b. SOCIAL SECURITY NO. 226-46-9121						17. INFORMANT ADDRESS CELESTIA HUDSON (same as 13 above)					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RENAL SHUTDOWN DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CHRONIC RENAL FAILURE DUE TO, OR AS A CONSEQUENCE OF (c)																		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																													
19a. DATE OF OPERATION						19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>						20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>											
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19						21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)																	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK						21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)						21f. LOCATION STREET CITY OR TOWN COUNTY STATE																	
22a. I certify that (if this hospital) attended the deceased from 1983, 19 to 4/14, 1986, that (I) (we) lost saw the deceased alive on 4/14, 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																													
22b. SIGNATURE Gary Beste M.D.												DEGREE				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 4/14/86									
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Gary Beste, M.D.												22e. ADDRESS NEWARK, DE																	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial						23b. DATE 4/18/86						23c. NAME OF CEMETERY OR CREMATORY Philadelphia Mem. PK.						23d. LOCATION CITY OR TOWN COUNTY STATE E. Whiteland Twp. Chester PA.											
24. FUNERAL DIRECTOR NAME RT. FRANK FUNERAL HOME												ADDRESS 1115 QUEEN ST. RISING SUN MD 21154				25a. DATE REC'D. BY REGISTRAR APR 18 1986				25b. REGISTRAR'S SIGNATURE [Signature]									

UNITED STATES DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION
WASHINGTON, D. C. 20535TO : DIRECTOR, FBI (100-441100)
FROM : SAC, NEW YORK (100-100000) (P)
SUBJECT: [REDACTED]RE: NEW YORK TELETYPE TO BUREAU, 1/11/68.
NEW YORK TELETYPE TO BUREAU, 1/11/68.FOR INFORMATION OF THE BUREAU, THE FOLLOWING
IS A SUMMARY OF THE INFORMATION RECEIVED FROM
THE NEW YORK OFFICE ON 1/11/68.ON 1/11/68, THE NEW YORK OFFICE RECEIVED
A TELEPHONE CALL FROM [REDACTED] WHO
STATED THAT HE HAD INFORMATION CONCERNING
THE [REDACTED] CASE.THE NEW YORK OFFICE IS CURRENTLY CONDUCTING
AN INVESTIGATION OF THIS MATTER AND
WILL KEEP THE BUREAU ADVISED OF ANY
DEVELOPMENTS.VERY TRULY YOURS,
[REDACTED]
SAC, NEW YORKENCLOSURE
100-100000-1000

[REDACTED]

[REDACTED]

[REDACTED]

00-03454

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8 6 1 1 4 4 5
REG. NO.

1 DECEASED NAME (TYPE OR PRINT) FIRST MARY MIDDLE R. LAST CAMERON			2a DATE OF DEATH MONTH DAY YEAR 4 9 86		2b HOUR 11:05 PM	
3 SEX Female		4 RACE WHITE		5 DATE OF BIRTH MONTH DAY YEAR 10 4 98		
6 AGE (IN YEARS LAST BIRTHDAY) 87 YRS.		7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b CITIZEN OF WHAT COUNTRY? USA		
8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Cecil MD.				
10 CITY OR TOWN OF DEATH Rising Sun		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Calvert Manor Nursing Home		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Telephone Operator		
12b KIND OF BUSINESS OR INDUSTRY						
13a STATE Maryland		13b COUNTY Cecil		13c CITY OR TOWN Rising Sun		
14 FATHER'S NAME FIRST MIDDLE LAST Robert		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elizabeth Crowl		16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		
16b SOCIAL SECURITY NO. 180-03-8347		17 INFORMANT ADDRESS Doris Nicholson, 41 N Main, St Port Deposit Md.				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiogenic shock</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>myocardial infarction</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>A.S.-C.V.D.</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 12 hrs. 4 days 10 yrs.	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)						
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME STREET FACTORY, OFFICE FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE		
22a I certify that (I) (this hospital) attended the deceased from <u>Jan 19 80</u> to <u>4-9 19 86</u> that (I) (we) last saw the deceased alive on <u>4-9 19 86</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.						
22b SIGNATURE DEGREE Neil Taylor MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED 4-10-86		
22d PHYSICIAN'S NAME (TYPE OR PRINT) Neil Taylor MD		22e ADDRESS Rising Sun, Md.				
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE 4-13-86		23c NAME OF CEMETERY OR CREMATORY Fairview Cemetery		
23d LOCATION CITY OR TOWN COUNTY STATE Calvert Cecil MD						
24 FUNERAL DIRECTOR NAME RT FORD Funeral Home		24b ADDRESS Rising Sun Maryland		25a DATE REC'D BY REGISTRAR APR 14 1986		
25b REGISTRAR'S SIGNATURE John Davidson						

MEDICAL CERTIFICATION

99

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death and be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

BP

1917-18
and 21
July 4
1917

1917-18
July 4
1917

00-05588

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILE. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201. PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
20M 4/82

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO.
1- STATE REGISTRAR										1 1 4 4 6
1. DECEASED NAME (TYPE OR PRINT) Stella Pritchitt Campbell						2a. DATE KNOWN OF DEATH ESTIMATED 4 28 86		2b. HOUR 1150 A		
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 5-11-1904	6. AGE (IN YEARS) LAST BIRTHDAY 81 YRS.	IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	IF UNDER 24 HRS.	2c. DATE PRONOUNCED DEAD 4 28 86		2d. HOUR 1150 A		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Cecil County				
10. CITY OR TOWN OF DEATH CONOWINGO		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 729 Ragan Rd.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE MD.		13b. COUNTY Cecil		13c. CITY OR TOWN Rising Sun		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 729 RAGAN Rd.		
14. FATHER'S NAME FIRST MIDDLE LAST HARRISON SAUNDER				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mollie CREGGARE						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Virginia P. Webb 8 Cherry Lane ELKTON, MD				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Atherosclerotic heart disease DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1										
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .										
ACTUAL SIGNATURE [Signature]				TITLE (SPECIFY) M.D. Deputy		MEDICAL EXAMINER		DATE SIGNED 4-28-86		
EXAMINER'S NAME (TYPE OR PRINT) Juan C Gonzalez-Vital				ADDRESS Union Hospital, Elkton MD 21921						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5/1/85		23c. NAME OF CEMETERY OR CREMATORY Oxford Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Oxford, Chester, Pa.				
24. FUNERAL DIRECTOR NAME ADDRESS RT. FOARD FUNERAL HOME Maryland.				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE MAY 5 1986 [Signature]				

00-04961

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

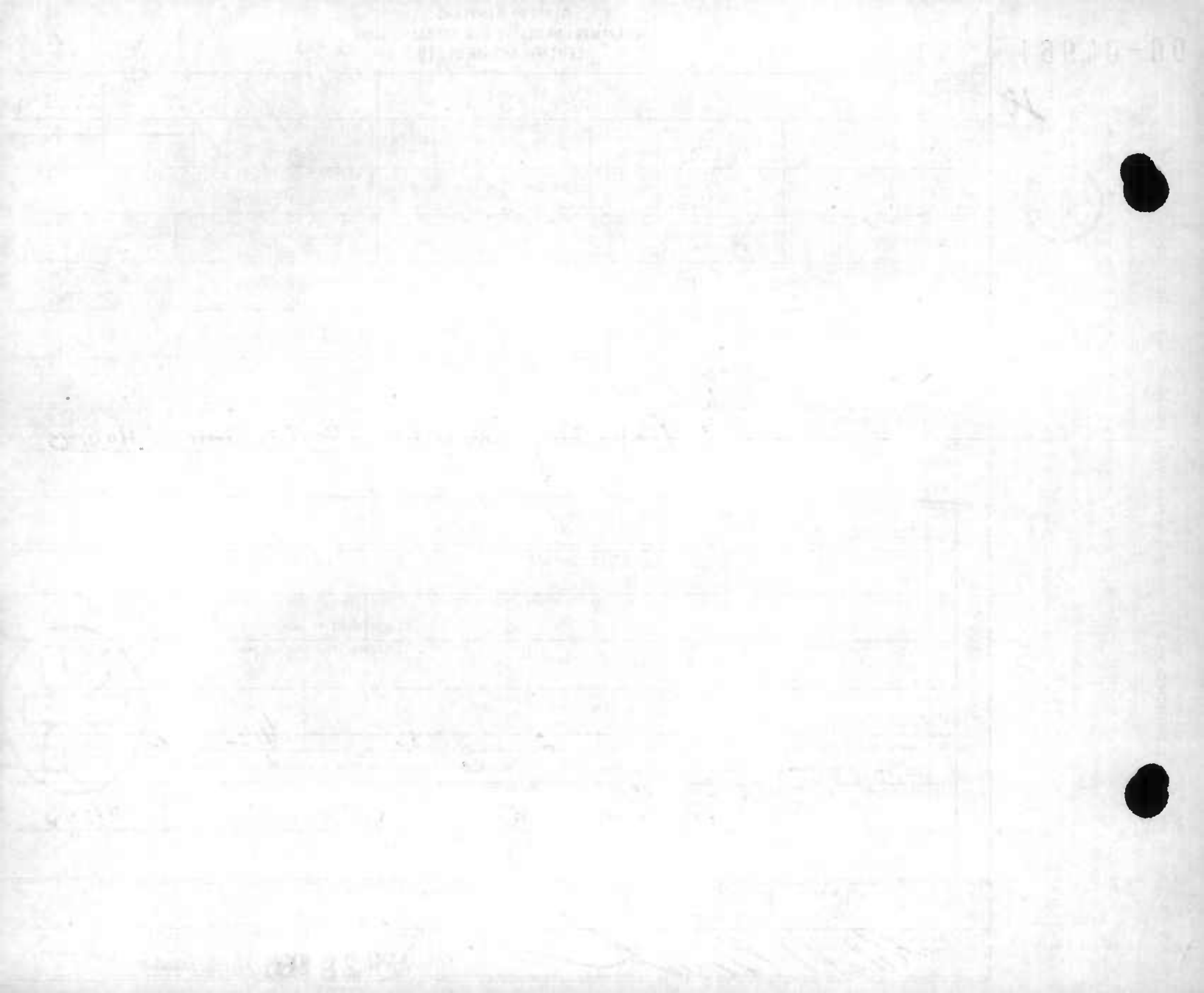
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the funeral home's office with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked on item 18, show any injury, or other traumatic event, the medical examiner must be notified.

DHMM - 16 50M 1/76
(VR A 15 (4))

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 86 11447	
1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST Allen Carlson Jr.		2a. DATE OF DEATH MONTH DAY YEAR 04/22/86		2b. HOUR 2148 M			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Feb. 19, 1926		6. AGE (IN YEARS LAST BIRTHDAY) 60 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Elkton, Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Cecil MD.					
10. CITY OR TOWN OF DEATH Elkton		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Unoin Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Self employed		12b. KIND OF BUSINESS OR INDUSTRY Car Sales			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE 13b. COUNTY 13c. CITY OR TOWN Md. Cecil North East				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 8 Oak Hill Lane 21901					
14. FATHER'S NAME FIRST MIDDLE LAST Allen Carlson Sr.				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Frances Louise Gladden							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN) Yes				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW II 217-20-1159		17. INFORMANT ADDRESS 1833 Brubaker Run Marsha C. Knowles Lancaster, Pa.					
18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Respiratory Compartment Heart Failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost										APPROXIMATE PERIOD BETWEEN ONSET AND DEATH MONTHS	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:10											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <u>2</u> , 19 <u>86</u> , to <u>4/22</u> , 19 <u>86</u> , that (I) (we) lost saw the deceased alive on <u>above</u> (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Donald M. Gino</u>				DEGREE <u>MD</u> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <u>4/24/86</u>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 4-26-86		23c. NAME OF CEMETERY OR CREMATORY North East Meth.		23d. LOCATION CITY OR TOWN COUNTY STATE North East Cecil Md.					
24. FUNERAL HOME <u>Funeral Home North East, Md.</u>				25a. DATE REC'D. BY REGISTRAR <u>APR 28 1986</u>		25b. REGISTRAR'S SIGNATURE <u>John Davidson</u>					

MEDICAL CERTIFICATION

11



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 1 1 4 4 8
REG. NO.

1 - FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) George W. Cowgill			2a. DATE OF DEATH MONTH DAY YEAR April 1, 1986			2b. HOUR 6:34P M			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Nov. 24, 1908		6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Penna.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Cecil			
10. CITY OR TOWN OF DEATH Perry Point		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Veterans Administration Medical Center				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Laborer		12b. KIND OF BUSINESS OR INDUSTRY Container Corp.	
13a. STATE Pa.		13b. COUNTY Philadelphia		13c. CITY OR TOWN Philadelphia		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 4150 Manayunk Ave. 99999	
14. FATHER'S NAME FIRST MIDDLE LAST George R. Cowgill			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Eva Miller						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE YEAR OR DATES) 180 18 7167		17. INFORMANT ADDRESS V.A.M.C. Records, Perry Point, Maryland.					

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **Cardiopulmonary arrest**

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.

(b) **Right lower lobe pneumonia**

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from November 3, 1981 to April 1, 1986 , that (we) last saw the deceased alive on April 1, 1986 , and that in (my/our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) did not view the body after death.							
22b. SIGNATURE Avelina C. Hernandez, M.D.						22c. DATE SIGNED 4-1-86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Avelina C. Hernandez, M.D.				22e. ADDRESS VA Medical Center, Perry Point, MD 21902			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE April 5, 1986		23c. NAME OF CEMETERY OR CREMATORY Mt. Vernon Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Philadelphia, Philadelphia, Pa.	
25a. DATE REC'D. BY REGISTRAR APR 09 1986				25b. REGISTRAR'S SIGNATURE John D. Turner			

00-04835

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1 1 4 4 9

1. DECEASED NAME (TYPE OR PRINT)			FIRST James			MIDDLE O.			LAST Cummerford			2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR			2b. HOUR 04-19-86 06:51 AM		
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR 02-06-31		6. AGE (IN YEARS) LAST BIRTHDAY 55Y YRS.		7. IF UNDER 1 YR. MONTHS DAYS		8. IF UNDER 24 HRS. HOURS MIN		2c. DATE PRONOUNCED DEAD 04-19-86 06:51 AM			2d. HOUR		
10. BIRTHPLACE (CITY AND COUNTY) Maryland				7b. CITIZEN OF WHAT COUNTRY? United States				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Cecil County MD.					
10. CITY OR TOWN OF DEATH Elkton				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Union Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Disabled Veteran				12b. KIND OF BUSINESS OR INDUSTRY Disabled					
13a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) Maryland				13b. COUNTY Cecil		13c. CITY OR TOWN Warwick		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 118 Wilson St 21912							
14. FATHER'S NAME Spry - Cummerford				15. MOTHER'S MAIDEN NAME Mollie - Benson													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, YES, OR UNKNOWN) Yes				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) Korean		217-28-4065		17. INFORMANT Jane A. Cummerford - Warwick Md									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ACUTE MI</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost: (b) <u>AS MD.</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Coronary Arteriosclerosis</u>														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 min 5 years? ?			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).																	
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?													
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion																	
ACTUAL SIGNATURE Peter Stavrakis				TITLE (SPECIFY) M.D. Capt.				MEDICAL EXAMINER				DATE SIGNED 4/19/86					
EXAMINER'S NAME (TYPE OR PRINT) PETER STAVRAKIS				ADDRESS ELKTON, CEIL - Md													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 4/23/86		23c. NAME OF CEMETERY OR CREMATORY Warwick Cem.				23d. LOCATION CITY OR TOWN COUNTY STATE Warwick-Cecil-Md.							
24. FUNERAL DIRECTOR Robert C. Hutchison				ADDRESS Middletown				25a. DATE REC'D. BY REGISTRAR APR 25 1986				25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall					

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM-PW 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
20M 4/82

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00-04543

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86

REG. NO.

11450

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
DECEASED NAME (TYPE OR PRINT)		MONTH DAY YEAR		MONTHS DAYS HOURS MIN.	
John C. Duncan SR.		April 18, 1986		12:20 PM	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)	
Male	White	MONTH DAY YEAR		79 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		9. BALTIMORE CITY OR COUNTY OF DEATH	
MD		USA		Cecil MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION		12a. USUAL OCCUPATION	
Rising Sun		Calvert Manor Nursing Home, Inc.		Construction	
13a. STATE		13b. CITY OR TOWN		13c. STREET ADDRESS / ZIP CODE	
MD		Rising Sun		945 Lombard Road 21911	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES?	
John C. Duncan		Annie Martin		No	
16b. SOCIAL SECURITY NO.		17. INFORMANT		18. CAUSE OF DEATH	
211-26-8114		Margaret Richardson		PART I. DEATH WAS CAUSED BY:	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		IMMEDIATE CAUSE (a)	
				Respiratory Arrest	
20a. ACCIDENT WAS UNDERLYING		20b. TIME OF INJURY		DUE TO, OR AS A CONSEQUENCE OF	
OR CONTRIBUTING CAUSE OF DEATH		HOUR A.M. MONTH DAY YEAR		(b) Terminal Ca. Diabetes mellitus	
(IF EITHER, NOTIFY MEDICAL EXAMINER)		P.M. 19		DUE TO, OR AS A CONSEQUENCE OF	
21d. INJURY OCCURRED		21e. PLACE OF INJURY		(c) Ca of stomach, Colon, Lung, ASCVD	
WHILE AT WORK NOT WHILE AT WORK		[AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.]		PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:	
22a. I certify that (I) (this hospital) attended the deceased from		22b. SIGNATURE		22c. DATE SIGNED	
above (I/we) (did) (did not) view the body after death.		Jui-Chin Hsu M.D.		4/21/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	
Jui-Chin Hsu, MD		223 W Main St, Elkton, MD 21921		BURIAL	
23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION	
4/22/1986		Oxford Cem.		Oxford, Chester, Penna	
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Richard L. Goodie		APR 24 1986			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

Department of State

RECEIVED

2000



4000 (copy 2) 10/10/00

RECEIVED

2000

10/10/00

10/10/00

10/10/00

00-05712

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8 6 1 1 4 5 1
REG. NO.

1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST S. Elizabeth Eller		2a. DATE OF DEATH MONTH DAY YEAR April 26, 1986		2b. HOUR 6 P.M.	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR April 29 1886		6. AGE (IN YEARS LAST BIRTHDAY) 99 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) North Carolina		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Cecil County, MD.			
10. CITY OR TOWN OF DEATH Elkton		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Laurelwood Nursing Center		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Own Home			
13a. STATE Maryland		13b. COUNTY Cecil		13c. CITY OR TOWN Elkton		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 100 Laurel Drive, 21921	
14. FATHER'S NAME FIRST MIDDLE LAST Rosa Miller		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Fannie Wyatt							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) ----- 164-28-6963		17. INFORMANT ADDRESS Laura M. Wyatt R.D. 1 Box 320 Delta, PA					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>congestive heart failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>ASCVD</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <u>Diabetes mellitus</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>1980</u> , 19____, to <u>present</u> , 19____, that (I) (we) last saw the deceased alive on <u>17 April</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. PHYSICIAN'S NAME (TYPE OR PRINT) Robert Gray M.D.				22c. ADDRESS M.D.				22d. DATE SIGNED 4/30/86	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 4/29/86		23c. NAME OF CEMETERY OR CREMATORY Baptist View Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Forest Hill Harford MD			
24. FUNERAL DIRECTOR NAME John Harkins 600 Main Street Delta, PA 17314				25a. DATE REC'D. BY REGISTRAR MAY 05 1986		25b. REGISTRAR'S SIGNATURE John Harkins			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return this certificate to the State Dept. of Health and Mental Hygiene with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner may be notified of this.

BP _____

0-2515

2014 COLON 2128



44

00-04832

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6

1 1 4 5 2

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <u>James B. Ezell</u>			2a. DATE OF DEATH MONTH DAY YEAR <u>4/21/86</u>			2b. HOUR <u>2027</u> M			
3. SEX <u>M</u>		4. RACE <u>W</u>		5. DATE OF BIRTH MONTH DAY YEAR <u>3 28 40</u>		6. AGE (IN YEARS LAST BIRTHDAY) <u>46</u> YRS		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>S.C.</u>		7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <u>Cecil</u> MD.			
10. CITY OR TOWN OF DEATH <u>ELKTON</u>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>UNION HOSPITAL</u>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>RET SALES</u>		12b. KIND OF BUSINESS OR INDUSTRY <u>SAEVAL</u>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE COUNTY CITY OR TOWN <u>MD</u> <u>CECIL</u> <u>CHESAPEAKE</u>				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS, ZIP CODE <u>100 BOHEMIA</u> <u>48</u>			

14. FATHER'S NAME FIRST MIDDLE LAST <u>W. W. EZZELL</u>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <u>DOROTHY K. BURNETT</u>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>NO</u>		16b. SOCIAL SECURITY NO. <u>248-62-5488</u>		17. INFORMANT ADDRESS <u>GREENVILLE S.C.</u>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary collapse / Multiorgan failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>pneumococcal sepsis / meningitis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>suspected alcohol induced liver disease</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Hours</u> <u>Days</u> <u>Months</u>
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: UGF bleeding / PUD; DIC.

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I, OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>4/11</u> , 19 <u>86</u> , to <u>4/21/86</u> , 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>4/21</u> , 19 <u>86</u> , and that (I) (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Robert Denitgie</u>				DEGREE <u>MD</u> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>4/22/86</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Robert Denitgie M.D.</u>				22e. ADDRESS <u>Cecil 10th. Md</u>			

23a. BURIAL, CREMATION, REMOVAL <u>BURIAL</u>		23b. DATE <u>4-26-86</u>		23c. NAME OF CEMETERY OR CREMATORY <u>FREDRICK MEM. CEMETERY</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>CECIL 10th. MD</u>	
24. FUNERAL DIRECTOR NAME ADDRESS <u>T. T. FORD FUNERAL HOME INC.</u>				25a. DATE REC'D. BY REGISTRAR <u>APR 25 1986</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. The low requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the non-transportation pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other final disposition. If item 21 is marked on item 20, a medical examiner's report is required. If item 21 is marked on item 20, a medical examiner's report is required.

BP.

00-04025



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be advised at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8611453

REG. NO.

FOR
1 - STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) HARRY E. FONTAINE JR			2a. DATE OF DEATH MONTH DAY YEAR APR 19, 1986			2b. HOUR 4:30 P.M.	
3. SEX MALE		4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR APR 14, 1918		6. AGE (IN YEARS LAST BIRTHDAY) 68 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Cecil County MD.	
10. CITY OR TOWN OF DEATH Elkton		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Union Hospital		12a. USUAL OCCUPATION (TYPE OR PRINT) Accountant		12b. KIND OF BUSINESS OR INDUSTRY Contractor	
13a. STATE Delaware		13b. COUNTY N.C.		13c. CITY OR TOWN Middletown		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME Harry E. Fontaine, Sr		15. MOTHER'S MAIDEN NAME Sarah Fontaine		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			
		16b. SOCIAL SECURITY NO. 223-18-0544		17. INFORMANT Mary W. Fontaine - Middletown, Del			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

acute myocardial infarction

DUE TO, OR AS A CONSEQUENCE OF

(b)

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

MEDICAL CERTIFICATION

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF OTHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHERE <input type="checkbox"/> AT HOME <input type="checkbox"/> HOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			

22a. I certify that (I) (this hospital) attended the deceased from **11-1, 1985** to **4-5, 1986**, that (I) (we) last saw the deceased alive on **4-5, 1986**, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

27b. SIGNATURE Kenneth Lewis, MD		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		27c. DATE SIGNED 4/21/86	
27d. PHYSICIAN'S NAME (TYPE OR PRINT) KENNETH LEWIS, MD		27e. ADDRESS 12 Pennington St Middletown, Del					

23a. BURIAL, CREMATION, REMOVAL Burial		23b. DATE Apr 24, 1986		23c. NAME OF CEMETERY OR CREMATORY Old Drawyers Cem		23d. LOCATION CITY OR TOWN COUNTY STATE Odessa - N.C. Del	
24. FUNERAL DIRECTOR Robert C. Hutchinson - Middletown, Del				25a. DATE REC'D. BY REGISTRAR APR 25 1986		25b. REGISTRAR'S SIGNATURE [Signature]	

HARRY E. FORTNAVE, JR.

APR 11 1918

W

Dear Sir,
I have the honor to acknowledge the receipt of your letter of the 10th inst. in relation to the above named case.
The same has been forwarded to the proper authorities for their consideration.
Very respectfully,
[Signature]

Very truly yours,
[Signature]
[Title]
[Address]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 22 is checked, any injury, or other traumatic event, the medical examiner must be notified immediately.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8611454
REG. NO.

1- FOR STATE REGISTRAR			2a DATE OF DEATH		2b HOUR	
DECEASED NAME (TYPE OR PRINT)			MONTH DAY YEAR		HOURS MIN.	
Andrew V. Frech			April 15, 1986		9:15 am	
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (IN YEARS LAST BIRTHDAY)		7 IF UNDER 1 YEAR	
Male	White	MONTH DAY YEAR Nov 9 1889	96 YRS.		MONTHS DAYS HOURS MIN.	
8 BIRTHPLACE (STATE OR FOREIGN COUNTRY)	9b CITIZEN OF WHAT COUNTRY?	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH		
PA	USA			Cecil MD.		
10 CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY	
Rising Sun	Calvert Manor Nursing Home, Inc.		Watchmaker		Mfg	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			13d INSIDE CITY LIMITS?		13e STREET ADDRESS / ZIP CODE	
13a STATE	13b COUNTY	13c CITY OR TOWN	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		48 Bonnie Shores 21921	
Md	Cecil	Elkton				
14 FATHER'S NAME			15 MOTHER'S MAIDEN NAME			
FIRST MIDDLE LAST Julius Frech			FIRST MIDDLE LAST Augusta Prinz			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b SOCIAL SECURITY NO.		17 INFORMANT	
No			165-10-3865		48 Bonnie Shores Andrew R. Frech Elkton, MD 21921	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Sepsis</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>24 hours</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a <u>Senile Dementia severe. Possible aspiration pneumonia.</u>						
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY?		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE		
22a I certify that (I) <u>Wallace G. Obenshein</u> attended the deceased from <u>Nov 84</u> to <u>Apr 15 1986</u> , that (I) <u>did</u> see the deceased alive on <u>Apr 15 1986</u> , and that in my <u>medical</u> opinion death occurred on the date and hour and from the causes stated above, (I) <u>did</u> view the body after death.						
22b SIGNATURE <u>Wallace Obenshein</u>				DEGREE M.D.		22c DATE SIGNED <u>15 Apr 86</u>
22d PHYSICIAN'S NAME (TYPE OR PRINT)				22e ADDRESS		
Wallace G. Obenshein, MD				Rt 213, Cecilton, MD 21913		
23a BURIAL, CREMATION, REMOVAL (SPECIFY)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION CITY OR TOWN COUNTY STATE
Entombment		4-18-86		Sunset Memorial Park		Somerton, Penna.
24 FUNERAL DIRECTOR <u>Frank E. Hicks</u>				25a DATE REC'D. BY REGISTRAR		25b REGISTRAR'S SIGNATURE
HICKS HOME for FUNERALS, ELKTON, MD. 21921				APR 23 1986		

BP

1. The first step is to identify the problem or question that needs to be answered. This involves understanding the context and the specific requirements of the task.

• 2009

00-03337

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

86 11455

1. DECEASED NAME (TYPE OR PRINT) <i>LEON F. Fye JR</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>4 3 86</i>			2b. HOUR <i>1301</i> M	
3. SEX <i>Male</i>		4. RACE <i>Caucasian</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>October 15, 1934</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>51</i> YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Wisconsin</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Cecil Co</i> MD.	
10. CITY OR TOWN OF DEATH <i>ELKTON</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Union Hospital of Cecil County</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Reg. Nurse</i>	
						12b. KIND OF BUSINESS OR INDUSTRY <i>Vet. Adm.</i>	

13a. RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				13e. STREET ADDRESS / ZIP CODE <i>124 Moffitt Street 21921</i>			
13a. STATE <i>Maryland</i>		13b. COUNTY <i>Cecil</i>		13c. CITY OR TOWN <i>Elkton</i>							
14. FATHER'S NAME FIRST MIDDLE LAST <i>Leon F. Fye, Sr.</i>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Blanche Martin</i>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>Yes</i>				16b. SOCIAL SECURITY NO. (IF YES, GIVE NUMBER) <i>6/12/82 - 331 26 1760</i>				17. INFORMANT ADDRESS <i>Janet Y. Fye, 124 Moffitt St., Elkton, Md. 21921</i>			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

*Cardiac arrest*APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH*1 hr.*

DUE TO, OR AS A CONSEQUENCE OF

(b) *Arteriosclerotic heart disease**2 mos.*

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a

Coronary cardiomyopathy; dilated myeloid

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
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21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
--	--	--	--	--	--

21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
---	--	--	--	---	--

22a. I certify that (I) the hospital attended the deceased from *9/2*, 19 *84*, to *4/3*, 19 *86*, that (II) (well last saw the deceased alive on *4/3*, 19 *86*, and that (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (do not) view the body after death.

22b. SIGNATURE <i>Edgar E. Folk 3rd MD.</i>			DEGREE <i>M.D.</i>			22c. DATE SIGNED <i>4/1</i>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Edgar E. Folk 3rd MD.</i>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL STAFF <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>					

22e. ADDRESS <i>Union Hospital, Elkton, MD 21921</i>					
---	--	--	--	--	--

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>4/7/86</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Gilpin Manor Mem. Park Cecil Md.</i>		23d. LOCATION CITY OR TOWN COUNTY STATE	
24. FUNERAL DIRECTOR NAME <i>Ralph E. Hicks</i> HICKS HOME FOR FUNERALS				25a. DATE REC'D. BY REGISTRAR <i>APR 11 1986</i>		25b. REGISTRAR'S SIGNATURE <i>Julia Davidson-Henderson</i>	

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00-04673

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMM - 16 60M 7/84
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. This page must be filed with the funeral director's office within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1- FOR STATE REGISTRAR		2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR		2c. TIME	
1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		4/17/86		620 A			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS (LAST BIRTHDAY))		7. UNDER 1 YEAR	
MALE		Negro		Dec. 27, 1897		88		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
N.C.		U.S.A.				Cecil Co		MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
EIKTON		UNION MEMORIAL		CAB DRIVER		Self Emp			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE	
Md.		Cecil		Port Deposit		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		965 Bainbridge Rd. 21904	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
DAYE		Gaddy		NANCY HUNTLEY		212-20-0147A		Zeford Gaddy - Port Deposit, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									
PART I. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) <u>Respiratory Arrest</u>									
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Gunshot Wound</u>									
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Chronic Arteriosclerosis with Stenosis</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Gastric/Intestinal Tumor</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
		HOUR A.M. MONTH DAY YEAR							
21d. INJURY OCCURRED		21e. PLACE OF INJURY		21f. LOCATION					
AT HOME <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> WHILE AT WORK <input type="checkbox"/>		[AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.]		STREET		CITY OR TOWN		COUNTY STATE	
22a. I certify that (1) this hospital attended the deceased from 12, 1985, to 4/16, 1986, that (2) (we) lost the deceased alive on 4/16, 1986, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (did) (did not) view the body after death)									
22b. SIGNATURE		DEGREE		22c. DATE SIGNED					
L. Woods		MD		4/17/86					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		22f. DATE RECEIVED BY REGISTRAR		22g. REGISTRAR'S SIGNATURE			
L. Woods		721 Bridge Street, EIKTON, MD 21921							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION			
BURIAL		Apr. 22-86		Beechey Cemetery		DARLINGTON-HAEFORD, Md.			
24. FUNERAL DIRECTOR		24a. ADDRESS		24b. CITY OR TOWN		24c. COUNTY		24d. STATE	
Ottis Bullock		Harrisburg, Md.		DARLINGTON		HAEFORD		Md.	

MALE Negro Nov 21/1881 28
M.C. N.S.A.

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Walter D. Black, New York, N.Y.
BORN: Apr. 27-28, 1886, Brooklyn, New York, U.S.A.

00-04646

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8 6 1 1 4 5 7
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Henrietta Minster Gardner			2a. DATE OF DEATH MONTH DAY YEAR April 17, 1986		2b. HOUR 2:00 A.M.
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR March 17, 1899		6. AGE (IN YEARS LAST BIRTHDAY) 87 YRS IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Elkton, Md.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH > Cecil MD.	
10. CITY OR TOWN OF DEATH Elkton	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Union Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker -	
13a. STATE Md.			13b. COUNTY Cecil	13c. CITY OR TOWN Elkton	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST J. Minster			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Emma Schwartz		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 217-46-2041		17. INFORMANT ADDRESS Baltimore, Md. Gwendolyn G. Logsdon 1268 Linden Ave.,	

18. CAUSE OF DEATH (Enter only one cause per line for 18a, 18b, and 18c. PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Heart Failure - Pulmonary Edema		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 48 hrs
DUE TO, OR AS A CONSEQUENCE OF (b) Acute Renal Failure - Azotemia		48 hrs
DUE TO, OR AS A CONSEQUENCE OF (c) Hypotension - Cerebrovascular Renal Disease		Over 1 yr.
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)		

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN IDENTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from April 15, 1986 to April 17, 1986 , that (I) (we) lost saw the deceased alive on April 16, 1986 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE S. RALPH AMONSON M.D.		DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 4/17/86
22d. PHYSICIAN'S NAME (TYPE OR PRINT) S. RALPH AMONSON M.D.		22e. ADDRESS 231 E. Main St. Elkton, Md. 21921	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 4-21-86	23c. NAME OF CEMETERY OR CREMATORY Elkton Cemetery	23d. LOCATION CITY OR TOWN COUNTY STATE Elkton Cecil Md.
24. FUNERAL DIRECTOR NAME GEE FUNERAL HOME, P.A. ADDRESS ELKTON, MD.		25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE APR 22 1986 Julia G. Logsdon	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper (Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition of the body.)

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of such.

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00-05487

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 1 1 4 5 8
REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		MONTH DAY YEAR		MONTH DAY YEAR	
MADELINE WEITHERS GARRETT		4 25 86		5 P.M.	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR	
Female	CAUC.	MONTH DAY YEAR	76	MONTHS DAYS HOURS MIN.	
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH		
VIRGINIA	USA		CECIL MD.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
ELKTON	UNION HOSPITAL OF CECIL CO		HOMEMAKER		HOME
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS	
MARYLAND	Cecil	Earleville	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	315 HAZELMOOR RD 21919	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME			
FIRST MIDDLE LAST		FIRST MIDDLE LAST			
DONALD WEITHERS		DAISEY SPANGLER			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
NO		N/A		143-22-0624 Shirley Zang - DAUGHTER - SAME	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY:					
IMMEDIATE CAUSE (a)					minutes
DUE TO, OR AS A CONSEQUENCE OF (b)					Hours
DUE TO, OR AS A CONSEQUENCE OF (c)					Years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)					
Anemia / Gastritis, hypercholesterolemia					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED	
		HOUR A.M. MONTH DAY YEAR		(ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED		21e. PLACE OF INJURY		21f. LOCATION	
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 4/25, 1986, to 4/25, 1986, that (I) (we) lost saw the deceased alive on 4/25, 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
R. DENITZIO		MD		4/25/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
R. DENITZIO		Cecil-Kent Cecilton MD 21913			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
CREMATION		4-26-86		SILVERBROOK CEM	
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
NAME ADDRESS		25c. DATE REC'D. BY REGISTRAR		25d. REGISTRAR'S SIGNATURE	
Fellows F.H. 226 E. MAIN ST Cecilton MD 21913		MAY 28 1986		Julia Davidson-Randall	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

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00-03082

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8 6 1 1 4 5 9
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Janiebell Groomes</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>Apr 4 86</i>		2b. HOUR <i>12 57 M</i>
3. SEX <i>Female</i>	4. RACE <i>Negro</i>	5. DATE OF BIRTH MONTH DAY YEAR <i>June 16 1919</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>66</i> YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 72 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>South Carolina</i>	7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Cecil</i> MD.	
10. CITY OR TOWN OF DEATH <i>Elkton</i>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Laurelwood Nursing Center</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>home maker</i>	12b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>	
13a. USUAL RESIDENCE (IF HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE COUNTY <i>Md. Kent</i>		13c. CITY OR TOWN <i>Galena</i>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE <i>Box 96 21635</i>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>Lawrance Jamison</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Frances Bostic</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>N/A</i>		16b. SOCIAL SECURITY NO. <i>217-42-6190</i>		17. INFORMANT ADDRESS <i>Ilean Blackston Galena, Md.</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Demyelinating Brain Disease</i> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>20 years</i>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a: <i>Decerebration, Inanition, total paralysis</i>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (the) <i>Janiebell</i> attended the deceased from <i>June</i> 19 <i>66</i> to <i>Apr 4</i> 19 <i>86</i> , that (I) (we) last saw the deceased alive on <i>4 Apr</i> 19 <i>86</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) <i>(did)</i> (do) view the body after death.					
22b. SIGNATURE <i>Wallace Obenshain</i> MD		DEGREE <i>MD</i>		22c. DATE SIGNED <i>4-04-86</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>WALLACE Obenshain</i>		22e. ADDRESS <i>Cecilton, Md. 21913</i>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>	23b. DATE <i>4/8/86</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Olivet Hill Cemetery</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Galena Kent Md.</i>	
24. FUNERAL DIRECTOR NAME <i>Fellows Funeral Home</i>		ADDRESS <i>Millington, Md.</i>		25. DATE REC'D. BY REGISTRAR <i>APR 10 1986</i>	
				REGISTRAR'S SIGNATURE <i>Julia Davidson</i>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corresponding pages 1 and 2 and file within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

0-03749

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8611460

FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME FIRST MIDDLE LAST Mildred G. Hardy			2a. DATE OF DEATH MONTH DAY YEAR Apr 14, 1986		2b. HOUR 2:35 AM
3 SEX Female	4 RACE White	5. DATE OF BIRTH MONTH DAY YEAR Aug 15 1913		6. AGE (IN YEARS LAST BIRTHDAY) 72	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. YRS.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PA	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Cecil MD.	
10. CITY OR TOWN OF DEATH Rising Sun	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Calvert Manor Nursing Home, Inc.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Practical Nurse	12b. KIND OF BUSINESS OR INDUSTRY Health	
13a. STATE MD			13b. CITY OR TOWN Harford	13c. STREET ADDRESS / ZIP CODE 4228 Webster Rd., 21078	
14. FATHER'S NAME FIRST MIDDLE LAST Charles Deaner		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Grace Dawson			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 214-34-3058		17. INFORMANT ADDRESS 100 Spring Lake Way Earl Deaner, Havre de Grace, MD 21078	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Hypertensive Aortic</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Heart Aortic</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 days
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 10					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>4/12</u> , 19 <u>86</u> , to <u>4/14</u> , 19 <u>86</u> , that (I) (we) lost saw the deceased alive on <u>4/12</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Malcolm Dudley Phillips</u>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 4/14/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Malcolm Dudley Phillips, MD		22e. ADDRESS Masonic Building, Darlington, MD 21034			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 4/17/86	23c. NAME OF CEMETERY OR CREMATORY Wesleyan Chapel Cem.	23d. LOCATION CITY OR TOWN COUNTY STATE Aberdeen, Harford, Maryland		
24. FUNERAL DIRECTOR Tarring Funeral Home, P.A., Aberdeen, MD, 21001-3399			25a. DATE REC'D. BY REGISTRAR APR 16 1986	25b. REGISTRAR'S SIGNATURE <u>Jana Davidson</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, a medical examiner or medical examiner's representative must be notified.

MEDICAL CERTIFICATION

BP

00-05310

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

86 11461

1. DECEASED NAME (TYPE OR PRINT) BERTHA		FIRST M.		LAST HITMAN		2a. DATE OF DEATH MONTH DAY YEAR APRIL 22, 1986		2b. HOUR P.M.	
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR OCTOBER 5, 1925		6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN. 60 YRS.		7. IF UNDER 1 YEAR IF UNDER 24 HRS.	
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		9. CITIZEN OF WHAT COUNTRY? U.S.A.		10. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		11. BALTIMORE CITY OR COUNTY OF DEATH CECIL COUNTY MD.			
12. CITY OR TOWN OF DEATH ELKTON		13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) UNION HOSPITAL OF CECIL COUNTY				14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOMEMAKER		15. KIND OF BUSINESS OR INDUSTRY	
16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 3a. STATE MARYLAND				13b. COUNTY CECIL		13c. CITY OR TOWN ELKTON		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
17. FATHER'S NAME FIRST MIDDLE LAST LINFIELD V. HUNT, SR.				18. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ANNA G. BROWN					
19a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		19b. SOCIAL SECURITY NO. 213 20 3363		17. INFORMANT ADDRESS ELKTON, MD 21921 ROGER D. HITMAN, 618 DELAWARE AVENUE					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio Respiratory Arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Artery Disease DUE TO, OR AS A CONSEQUENCE OF (c) Renal Vascular Hypertension APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 721 BRIDGE STREET, ELKTON, . CECIL MD.					
22a. I certify that (I) (this hospital) attended the deceased from 6/15 19 64 to 9/22 19 86 , that (I) (we) lost 6/15 19 86 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.									
22b. SIGNATURE Joseph G. Lanzi				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 4-24-86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JOSEPH G. LANZI, M.D.				22e. ADDRESS 721 BRIDGE STREET, ELKTON, MD. 21921					
23a. BURIAL, CREMATION, REMOVAL (TYPE) BURIAL		23b. DATE 4/25/86		23c. NAME OF CEMETERY OR CREMATORY ELKTON CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE ELKTON, . CECIL MD.			
24. FUNERAL DIRECTOR HICKS HOME FOR FUNERALS Ralph E. Hicks				ADDRESS ELKTON, MD.		25a. DATE REC'D. BY REGISTRAR MAY 1 1986		25b. REGISTRAR'S SIGNATURE Julia Davidson	

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

BP

2015

ATLANTA, GEORGIA
JANUARY 1, 1915

2015

00-02782

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86 11462
REG. NO.

1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)		FIRST HAROLD		MIDDLE RUSSELL		LAST HUTSON		2a. DATE OF DEATH MONTH DAY YEAR April 4, 1986		2b. HOUR 12:30pm	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR March 27, 1904		6. AGE (IN YEARS LAST BIRTHDAY) 82		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Creswell, Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Cecil County MD.							
10. CITY OR TOWN OF DEATH Perry Point, Md.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) VA Medical Center		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Civilian Gunner		12b. KIND OF BUSINESS OR INDUSTRY USgovt-Ret.							
13a. STATE Maryland		13b. CITY OR TOWN Harford		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13d. STREET ADDRESS / ZIP CODE 1217 ABingdon Road 21009							
14. FATHER'S NAME FIRST MIDDLE LAST William Henry Hutson		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Alice Rebecca Oliver											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WWII		17. INFORMANT ADDRESS Abingdon, Md. 21009 Alice E. Hutson, 1217 Abingdon Road									
18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (SAY HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>June 3</u> 19 <u>85</u> to <u>April 4</u> 19 <u>86</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. I swear that I told you the above after death.													
22b. SIGNATURE <i>Abid Mohiuddin</i>		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 4-4-86									
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ABID MOHIUDDIN, M.D.		22e. ADDRESS VA Medical Center, Perry Point, Md.											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Apr. 7, 1986		23c. NAME OF CEMETERY OR CREMATORY Calvary U. Methodist Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Churchville Harford Md.							
24. FUNERAL DIRECTOR NAME Howard McComas III		ADDRESS 21009 Abingdon, Md.		25a. DATE REC'D. BY REGISTRAR APR 7 1986		25b. REGISTRAR'S SIGNATURE <i>James H. ...</i>							

00-04083

 FOR Film G615 item 22a
 1- STATE REGISTRAR 5/27/86 rja

 DEPARTMENT OF HEALTH AND MENTAL HYGIENE
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 1 1 4 6 3

1. DECEASED NAME (TYPE OR PRINT) GEORGE LEE IVEY, Sr.			2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH 4 DAY 13 YEAR 86			2b. HOUR M		
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH Nov. DAY 3 YEAR 1913	6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS.	IF UNDER 1 YR. MONTHS 72 DAYS 72 HOURS 72 MIN.	7c. DATE PRONOUNCED DEAD 4-13-86			7d. HOUR M
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Hartford, Ala.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Cecil County MD.		
10. CITY OR TOWN OF DEATH Elkton		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 39 Stoney Chase Ct.			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired- Avon Products		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Md.		13b. COUNTY Cecil	13c. CITY OR TOWN Elkton	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS 39 Stoney Chase Drive			
14. FATHER'S NAME FIRST Alonzo MIDDLE Ivey LAST Ivey				15. MOTHER'S MAIDEN NAME FIRST Lacey MIDDLE Spikes LAST Spikes				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 265-03-2597		17. INFORMANT Ethel M. Ivey ADDRESS Elkton, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gunshot wound of head DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? (HEAD ONLY) YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY 10:55AM 4-13-86		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) self/inflicted				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) home		21f. LOCATION STREET 39 Stoney Chase Ct. CITY OR TOWN Elkton COUNTY Maryland STATE				
22a. I certify that I took charge of the remains described above (HEAD ONLY) <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE Margarita A. Korell		TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER					DATE SIGNED 4-14-86	
EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Korell, M.D.		ADDRESS 111 Penn Street						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 4-17-86		23c. NAME OF CEMETERY OR CREMATORY Union Church Cem.		23d. LOCATION CITY OR TOWN Elkton COUNTY Cecil STATE Md.		
24. FUNERAL DIRECTOR Gee Funeral Home, P.A.				25a. DATE REC'D. BY REGISTRAR APR 17 1986		25b. REGISTRAR'S SIGNATURE Gee		

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25M

BP

DHMH - 17
(VR A15 ME (5))



00-03511

1. FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

18611464

1. DECEASED NAME (TYPE OR PRINT) CHARLES L. JACKSON, Sr.			2a. DATE OF DEATH MONTH DAY YEAR 4 5 86			2b. HOUR 6P M			
3. SEX M		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR 11 19 1895		6. AGE (IN YEARS LAST BIRTHDAY) 70 YRS		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Cecil MD.			
10. CITY OR TOWN OF DEATH CALVERT MD		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) CALVERT MANOR NURS. HOME, Inc.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) FARMER		12b. KIND OF BUSINESS OR INDUSTRY FARMING	
13a. STATE Pennsylvania		13b. COUNTY LANCASTER		13c. CITY OR TOWN Gettysburg		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
14. FATHER'S NAME FIRST MIDDLE LAST Joseph R. JACKSON		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Stella RETZER		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) yes W.W.I					
16b. SOCIAL SECURITY NO. 197-36-5816		17. INFORMANT MARY L. HESS				ADDRESS R.R. #1 Box 213 CHRISTIANA, PA. 17507			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>respiratory failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>respiratory congestion</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>congestive heart failure and pneumonia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u> <u>5 days</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <u>ASCVD - senility</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (1) (this hospital) attended the deceased from <u>Mar 29</u> 19 <u>86</u> , to <u>Apr 5</u> 19 <u>86</u> , that (2) (we) last saw the deceased alive on <u>Apr 1</u> 19 <u>86</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (3) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Faye R. Doyle MD				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED Apr 8, 86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) FAYE R. DOYLE MD				22e. ADDRESS 133 LOCUST ST. OXFORD, PA 19363					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 4-9-86		23c. NAME OF CEMETERY OR CREMATORY Little Britain Presby. Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Fulton Twp. Lancaster PA.			
24. FUNERAL DIRECTOR NAME ADDRESS FRED Reynolds, 144 E. State, Quarryville PA				25a. DATE REC'D. BY REGISTRAR APR 11 1986		25b. REGISTRAR'S SIGNATURE Julie Davidson-Randall			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be completely filled in by the funeral director, page 3 should be detached for use at the burial/transit permit. Then please remove carbon pages 1 and 2 and place them in the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18, makes any injury, or other traumatic event, the medical examiner will be notified and page 4 may be retained by the hospital or attending physician.

999999

RECEIVED

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00-06123

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25M
 BP _____
 DHMH - 17
 (VR A15 ME (5))

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 11465	
1. DECEASED NAME FIRST MIDDLE LAST Robert H. Kane						2a. DATE KNOWN OF DEATH MONTH DAY YEAR 4 28 1986		2b. HOUR M 6 55 P			
3. SEX Male		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 11 2 1921		6. AGE (IN YEARS) LAST BIRTHDAY 64 YRS.		7. IF UNDER 24 HRS. MONTHS DAYS HOURS MIN. 0 0 0 0		7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 4 28 1986	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Cecil County MD		
10. CITY OR TOWN OF DEATH Elkton			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 311 Friendship Road				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Truck Driver		12b. KIND OF BUSINESS OR INDUSTRY Auto Parts		
13a. STATE Maryland			13b. COUNTY Cecil		13c. CITY OR TOWN Elkton		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 311 Friendship Road		
14. FATHER'S NAME FIRST MIDDLE LAST Charles L. Kane (D)						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sophia - Green					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes				16b. SOCIAL SECURITY NO. 215-16-6234		17. INFORMANT ADDRESS Barbara Kane 112 Collins Ave. Elkton, MD					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of esophagus DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH										PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):	
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE L. Vital				TITLE (SPECIFY) Deputy M.D.				MEDICAL EXAMINER DATE SIGNED 4-28-86			
EXAMINER'S NAME (TYPE OR PRINT) Juan C Gonzalez-Vital				ADDRESS Union Hospital Elkton MD 21921							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 5-3-1986		23c. NAME OF CEMETERY OR CREMATORY Bohemia Manor Cemetery			23d. LOCATION CITY OR TOWN COUNTY STATE Chesapeake Maryland			
24. FUNERAL DIRECTOR NAME Stewart Funeral Home						25a. DATE REC'D. BY REGISTRAR MAY 9 1986			25b. REGISTRAR'S SIGNATURE [Signature]		

MEDICAL CERTIFICATION

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00-03457

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8 6 1 1 4 6 6
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <i>Arnold C. Kirby</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>4-10-1986</i>		2b. HOUR <i>0644</i>				
3. SEX <i>Male</i>		4. RACE <i>White</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>June 22 1929</i>		6. AGE (IN YEARS LAST BIRTHDAY) YRS <i>57</i>			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>W. Va.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Cecil Co</i> MD.			
10. CITY OR TOWN OF DEATH <i>Elkton</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Union Hospital</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Super.</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Govt.</i>			
13a. STATE <i>Md.</i>			13b. CITY OR TOWN <i>Cecil North East</i>		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS / ZIP CODE <i>120 N. Main St. 21901</i>		
14. FATHER'S NAME FIRST MIDDLE LAST <i>Andrew E. Kirby Sr.</i>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Mary A. Snyder</i>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES <input checked="" type="checkbox"/> OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <i>Korea 233-49-5179</i>		17. INFORMANT ADDRESS <i>120 N. Main St. Oleita Kirby North East, Md., 21901</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac Arrest</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Myocardial Infarction</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Coronary Artery Disease</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <i>Cholecystectomy</i>									
19a. DATE OF OPERATION <i>4.9.86</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Cholelithiasis</i>			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <i>Jan</i> , 19 <i>86</i> , to <i>4.10</i> 19 <i>86</i> , that (I) (we) lost saw the deceased alive on <i>4.10</i> 19 <i>86</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>Sheelmoohan S. Sachdev M.D.</i>				DEGREE <i>M.D.</i>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>4.10.86</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>SHEELMOHAN S. SACHDEV, M.D.</i>				22e. ADDRESS <i>202 Bow St, ELKTON MD 21921</i>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>4-12-86</i>		23c. NAME OF CEMETERY OR CREMATORY <i>North East Meth.</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>North East Cecil Md.</i>			
24. FUNERAL DIRECTOR NAME <i>Grouch Funeral Home North East</i>				25a. REC'D. BY REGISTRAR <i>APR 14 1986</i>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

BP

20% COTTON FIBER

100% MILKMAKERS



MADE IN U.S.A.

REGISTERED PATENT

MADE IN U.S.A.

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00-03496

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86 REG. NO. 11467

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) PAULINE		FIRST KRISL		LAST		2a. DATE OF DEATH MONTH DAY YEAR APRIL 5, 1986		2b. HOUR 2:45P M	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Dec. 30, 1912		6. AGE (IN YEARS LAST BIRTHDAY) 73		7. YRS. MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Czechoslovakia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Cecil MD.			
10. CITY OR TOWN OF DEATH PERRY POINT, MD.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) VA MEDICAL CENTER				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Artist		12b. KIND OF BUSINESS OR INDUSTRY self	
13a. RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland		13b. COUNTY Harford		13c. CITY OR TOWN Havre de Grace		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 313 S. Washington Street 21902	
14. FATHER'S NAME FIRST MIDDLE LAST John		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ann Smraha		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes (IF YES, GIVE WAR OR DATES) WWII					
16b. SOCIAL SECURITY NO. 336-07-5874		17. INFORMANT ADDRESS V.A.M.C. Records, Perry Point, Maryland.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute cardiac arrest								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								(b) Generalized arteriosclerosis (c) Diabetes mellitus, Insulin dependent	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from JANUARY 23 , 19 86 , to APRIL 5 , 19 86 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on APRIL 5 , 19 86 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, or (we) (did) (did not) view the body after death.									
22b. SIGNATURE Joaquin R. Garcia		DEGREE M.D.		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED 5 am 86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JOAQUIN R. GARCIA, M.D.		22e. ADDRESS VA Medical Center, Perry Point, MD. 21902							
23a. BURIAL, CREMATION, REMOVAL Crema		23b. DATE April 8, 1986		23c. NAME OF CEMETERY OR CREMATORY R.A. Ferris Co. Crematory West Chester, W. Goshen, Pa.		23d. LOCATION CITY OR TOWN COUNTY STATE			
24. FUNERAL DIRECTOR Patterson & Son		ADDRESS Perryville, MD. 21903		25a. DATE REG'D. BY REGISTRAR APR 14 1986		25b. REGISTRAR'S SIGNATURE			

MEDICAL CERTIFICATION

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/interment permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

Genus *Phlox*
Species *subulnifolia*

White
new

Dec

30, 1915

X

37
Locality

alt. 10000

13.2. Washington Street

Mountain, near road, above the house X

Grass

near trail

low

1. 1. 1. Records, 1915, only, Washington.

11 1/2



Genus *Phlox*, 1915, near Washington Street, alt. 10000.

00-03588

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner or the medical examiner's designee must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR									
1. DECEASED NAME (TYPE OR PRINT) George E. Lang, Jr.						2a. DATE OF DEATH Apr 14 1986		2b. HOUR 3:00AM	
3. SEX Male		4. RACE White		5. DATE OF BIRTH Jan 3 1894		6. AGE (IN YEARS LAST BIRTHDAY) 92		7. IF UNDER 1 YEAR MONTHS DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Cecil MD.			
10. CITY OR TOWN OF DEATH Rising Sun		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Calvert Manor Nursing Home, Inc.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Engineer		12b. KIND OF BUSINESS OR INDUSTRY Industrial	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) MD STATE		13b. COUNTY Balto		13c. CITY OR TOWN Parkville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 2902 Linwood Ave, 21234	
14. FATHER'S NAME George E. Lang, Sr.				15. MOTHER'S MAIDEN NAME XXXXXXXX Teresa Trautmann					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 213-01-4251		17. INFORMANT George E. Lang III 302 Country Club Drive Newark, Del. 19711					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary heart failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>A.S.C.V.D.</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Smoker</u> Approximate interval between onset and death: <u>10 days</u> <u>5 pm.</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)									
19a. DATE OF OPERATION <u>6-15</u>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Smoker</u>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>6-15</u> 19 <u>84</u> , to <u>4-13</u> 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>4-13</u> 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Neil R. Taylor, Jr.</u>		DEGREE <u>MD</u>		22c. DATE SIGNED <u>4-14-86</u>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Neil R. Taylor, Jr., MD				22e. ADDRESS Haines Ave & Walnut, Rising Sun, Md, 21911					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Apr. 15, 1986		23c. NAME OF CEMETERY OR CREMATORY Moreland Mem. Pk.		23d. LOCATION CITY OR TOWN COUNTY STATE Parkville, Balto., Md.			
24. FUNERAL DIRECTOR ROBERT C. ALTENBURG FUNERAL HOME, INC. 6009 Harford Rd., Balto., Md. 21214				25a. DATE REC'D. BY REGISTRAR APR 15 1986		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

00-03456

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP.

DHMH - 16 60M 7/B4
(VRA 15, 4)

Film 6615 item 14

FOR 5/1/86 rja
1- STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8 6 1 1 4 6 9
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <u>LEX</u> <u>W</u> <u>LUCAS</u>			2a. DATE OF DEATH MONTH <u>4</u> DAY <u>9</u> YEAR <u>86</u>		2b. HOUR <u>145</u> M
3. SEX <u>Male</u>	4. RACE <u>White</u>	5. DATE OF BIRTH MONTH <u>2</u> DAY <u>1907</u> YEAR	6. AGE (IN YEARS LAST BIRTHDAY) <u>78</u> YRS.		IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Va.</u>	7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <u>Cecil Co</u> MD.		
10. CITY OR TOWN OF DEATH <u>EIKTON</u>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Union Hospital</u>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Self-employed</u>		12b. KIND OF BUSINESS OR INDUSTRY <u>Landscaper</u>
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <u>Md.</u> 13a. COUNTY <u>Cecil</u> 13a. CITY OR TOWN <u>North East</u>			13b. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST <u>William</u> MIDDLE <u>Q.</u> LAST <u>Lucas</u>			15. MOTHER'S MAIDEN NAME FIRST <u>Arminda</u> MIDDLE <u>Craghead</u> LAST		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>No</u>		16b. SOCIAL SECURITY NO. <u>152-05-2317</u>		17. INFORMANT <u>202 Rivermanor Apts.</u> <u>Lelia Lucas North East, Md. 21901</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerotic cardiovascular disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Diabetes mellitus</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u> <u>years</u> <u>years</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>chronic depressive; Abdominal aortic aneurysm, PVC's</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>October</u> 19 <u>84</u> to <u>April 9</u> 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>April 8</u> 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Charles M. Hengsten</u>				22c. DATE SIGNED <u>April 10, 1986</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Charles M. Hengsten</u>		22e. ADDRESS <u>North East Md</u>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		23b. DATE <u>4-12-86</u>		23c. NAME OF CEMETERY OR CREMATORY <u>North East Meth.</u>	
23d. LOCATION <u>North East Cecil Md.</u>		23e. STATE			
24. FUNERAL DIRECTOR NAME <u>John Hengsten</u> ADDRESS <u>North East, Md</u>				25a. DATE REC'D. BY REGISTRAR <u>APR 14 1986</u>	
25b. REGISTRAR'S SIGNATURE <u>John Hengsten</u>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filed in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the funeral director within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a medical examination required.

[Faint, illegible text and markings across the page, possibly bleed-through from the reverse side. Some faint lines and shapes are visible.]

00-05002

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN THE SPACE PROVIDED. THE MEDICAL EXAMINER'S JOURNAL, PAGE 4, SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25M
 BP
DHMH - 17
(VR A15 ME (5))

 STATE OF MARYLAND
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 11470

 FOR
 STATE
 REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Theresa D. Matlaga		2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 4 22 1986		2b. HOUR M 6:35 P
3. SEX female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Mar. 26, 1925	6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS HOURS MIN 65	7. IF UNDER 1 YR. IF UNDER 24 HRS.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Bethlehem, Pa.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
10. CITY OR TOWN OF DEATH Elkton		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION 207 Atlanta Court		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ret. Pharmaceutical
13a. STATE Md.		13b. COUNTY Cecil	13c. CITY OR TOWN Elkton	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Michael Grasic		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 203-09-2384		17. INFORMANT ADDRESS Elkton, Md. Stephen Matlaga 207 Atlanta Ct.,
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular accident DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .				
ACTUAL SIGNATURE J. Grasic		TITLE (SPECIFY) Deputy		DATE SIGNED 4-22-86
EXAMINER'S NAME (TYPE OR PRINT) Juan C Gonzalez-Vital MD		ADDRESS Union Hospital, Elkton MD 21921		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b. DATE APRIL 26 1986	23c. NAME OF CEMETERY OR CREMATORY Holy SAUVOR R.C. Cemetery	23d. LOCATION CITY OR TOWN COUNTY STATE Bethlehem Northampton Pa.	
24. FUNERAL DIRECTOR NAME Edward McKeown ADDRESS 259 E. MAIN ST ELKTON		25a. DATE REC'D. BY REGISTRAR APR 28 1986	25b. REGISTRAR'S SIGNATURE John Deaton-Randall	

00-05626

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8 6 1 1 4 7 1
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <i>Nancy I McConnell</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>4/25/86</i>			2b. HOUR <i>945 A</i>				
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR <i>August 26, 1921</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>64</i> YRS.		7. UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) INDIANA		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Cecil Co</i> MD.				
10. CITY OR TOWN OF DEATH <i>ELKTON</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) UNION HOSPITAL OF CECIL COUNTY				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOMEMAKER		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE DELAWARE			13b. COUNTY NEW CASTLE		13c. CITY OR TOWN KIRKWOOD		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
14. FATHER'S NAME FIRST MIDDLE LAST (UNKNOWN)			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST (UNKNOWN)			13e. STREET ADDRESS / ZIP CODE <i>309 HOWELL SCHOOL RD. 19708</i>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. 230 22 3936		17. INFORMANT ADDRESS <i>309 Howell School Rd., Kirkwood, Del. 19708</i>					
18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Gram (-) sepsis</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>urinary tract infection</i> DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <i>diabetes mellitus</i>										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <i>Kenneth Lewis MD</i>						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>5/3/86</i>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Kenneth Lewis MD</i>					22e. ADDRESS <i>12 PENNINGTON ST., MIDDLETOWN, DE. 19709</i>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE <i>Apr. 29, 1986</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Gracelawn Memorial Pk.</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Wilmington, New Castle Del.</i>			
24. FUNERAL DIRECTOR <i>Ralph E. Hicks</i> HICKS HOME FOR FUNERALS					ADDRESS <i>ELKTON, MD.</i>		25a. DATE REC'D. BY REGISTRAR MAY 6 1986		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.



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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8 6 1 1 4 7 2
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST DOROTHY C. NELSON			2a. DATE OF DEATH MONTH DAY YEAR APRIL 25, 1986		2b. HOUR PM
3. SEX FEMALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR JULY 20, 1907		6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH CECIL MD.	
10. CITY OR TOWN OF DEATH ELKTON	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) DEVINE HAVEN NURSING HOME		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RECORDS - CLERK	12b. KIND OF BUSINESS OR INDUSTRY AUTO MFG	
13a. STATE MARYLAND		13b. COUNTY CECIL	13c. CITY OR TOWN ELKTON	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST SPENCER HARRISON MEREDITH		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST CHARLOTTE WHITERED PROCTOR		150 E. MAIN ST., 21921	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 010 26 0197		17. INFORMANT ADDRESS Danna C. Short, 102 N. Park Circle, 21921 Elkton, Md	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Small cell carcinoma of the left lung</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>6 months</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Cirrhosis of the liver</u>					
9a. DATE OF OPERATION		9b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (the hospital) attended the deceased from <u>Nov. 3</u> , 19 <u>85</u> , to <u>April 25</u> , 19 <u>86</u> , that (I) (we) lost saw the deceased alive on <u>April 25</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>[Signature]</u>		DEGREE <u>MD</u>		22c. DATE SIGNED <u>4/26/86</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>S. R. Anderson, MD</u>		22e. ADDRESS <u>2335 Main St, Elkton, Md 21921</u>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b. DATE 4/28/86	23c. NAME OF CEMETERY OR CREMATORY GILPIN MANOR MEM. PARK		23d. LOCATION CITY OR TOWN COUNTY STATE ELKTON CECIL MARYLAND	
24. FUNERAL DIRECTOR NAME <u>HICKS HOME FOR FUNERALS</u>		ADDRESS <u>ELKTON, MD.</u>		25a. DATE REC'D. BY REGISTRAR MAY 1 1986	25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed filed in by the funeral director, page 3 should be detached for use on the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must file a report and a copy of the report must be filed with the State Dept. of Health and Mental Hygiene.

8-3217-10100-000

WATER



11826-00

00-04026

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		MONTH DAY YEAR		P M	
FIRST MIDDLE LAST		April 8, 1986		2340 P M	
3. SEX		4. RACE		5. DATE OF BIRTH	
Male		Caucasian		MONTH DAY YEAR	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
Delaware		USA		9. BALTIMORE CITY OR COUNTY OF DEATH	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
Elkton		Union Hospital		Ret. Carpenter	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN	
Maryland		Cecil		Elkton	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		13d. STREET ADDRESS	
FIRST MIDDLE LAST		FIRST MIDDLE LAST		RD #7, Box #139	
Harry C. Nickle		Susan Nickle		21921	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
NO		222-01-6159		William A. Nickle, Barefoot Bay, Florida	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					
PART I. DEATH WAS CAUSED BY:					
IMMEDIATE CAUSE (a) BRONCHITIS & PNEUMONIA					
DUE TO, OR AS A CONSEQUENCE OF					
(b) CONGESTIVE HEART FAILURE					
DUE TO, OR AS A CONSEQUENCE OF					
(c) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	
				YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
		P.M. 19			
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION	
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 3-11-86, to 4-8-86, that (I) (we) last saw the deceased alive on 4-8-86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE				22c. DATE SIGNED	
Rolando A. Najera, M.D.				4-9-86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS	
Rolando A. Najera, M.D.				105 E. Main Street, Elkton, Maryland 21921	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Burial		4/12/86		New St. Paul's Cem.	
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Hicks Home for Funerals, Elkton, Md.		APR 18 1986			

BP

APR 11 1984 3:40 P

102 E. Main Street, Elkhart, Indiana 21021

Elkhart, Indiana, U.S.A.

Elkhart, Indiana, U.S.A.

00-02993

Film 6515 ite 1,14

1- FOR STATE REGISTRAR 5/5/86 rja

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8611474
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Arnold 7 NOWLAND Noland			2a. DATE OF DEATH MONTH DAY YEAR 4/4/86		2b. HOUR 210 M
3. SEX MALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR 2 7 1901		6. AGE (IN YEARS LAST BIRTHDAY) 85 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Cecil Co MD.	
10. CITY OR TOWN OF DEATH EIKTOW	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) UNION HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) DECK HAND	12b. KIND OF BUSINESS OR INDUSTRY ARMY CORP ENG.	
13a. STATE MD		13b. COUNTY Cecil	13c. CITY OR TOWN CHESAPEAKE CITY	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 230 BIDDLE ST 21915
14. FATHER'S NAME FIRST MIDDLE LAST Wm T. NOWLAND		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARTHA HUDSON			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO 164-20-1564		17. INFORMANT ADDRESS GLADYS V. CALEB 13 BOWEN	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiovascular Collapse DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) Septic Shock DUE TO, OR AS A CONSEQUENCE OF (c) UTI / Pneumonia					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) CVA w/ (b) hemiparesis (c) CHF					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE R. Deitzio		DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Robert Deitzio		22e. ADDRESS Cecil Co Md			
23a. BURIAL, CREMATION, REMOVAL (SEE INSTRUCTIONS) BURIAL	23b. DATE 4-7-86	23c. NAME OF CEMETERY OR CREMATORY Bethel Cemetery	23d. LOCATION CITY OR TOWN COUNTY STATE Chesapeake City Cecil Co MD		
24. FUNERAL DIRECTOR NAME RT FRANK FUNERAL HOME		ADDRESS Chesapeake City Maryland		25a. DATE REC'D. BY REGISTRAR APR 9 1986	25b. REGISTRAR'S SIGNATURE John Davidson

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 may be retained by the funeral director. Page 3 should be retained by the funeral director. Page 4 may be retained by the funeral director.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP _____

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00-03338

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18, the medical examiner must be notified at once.

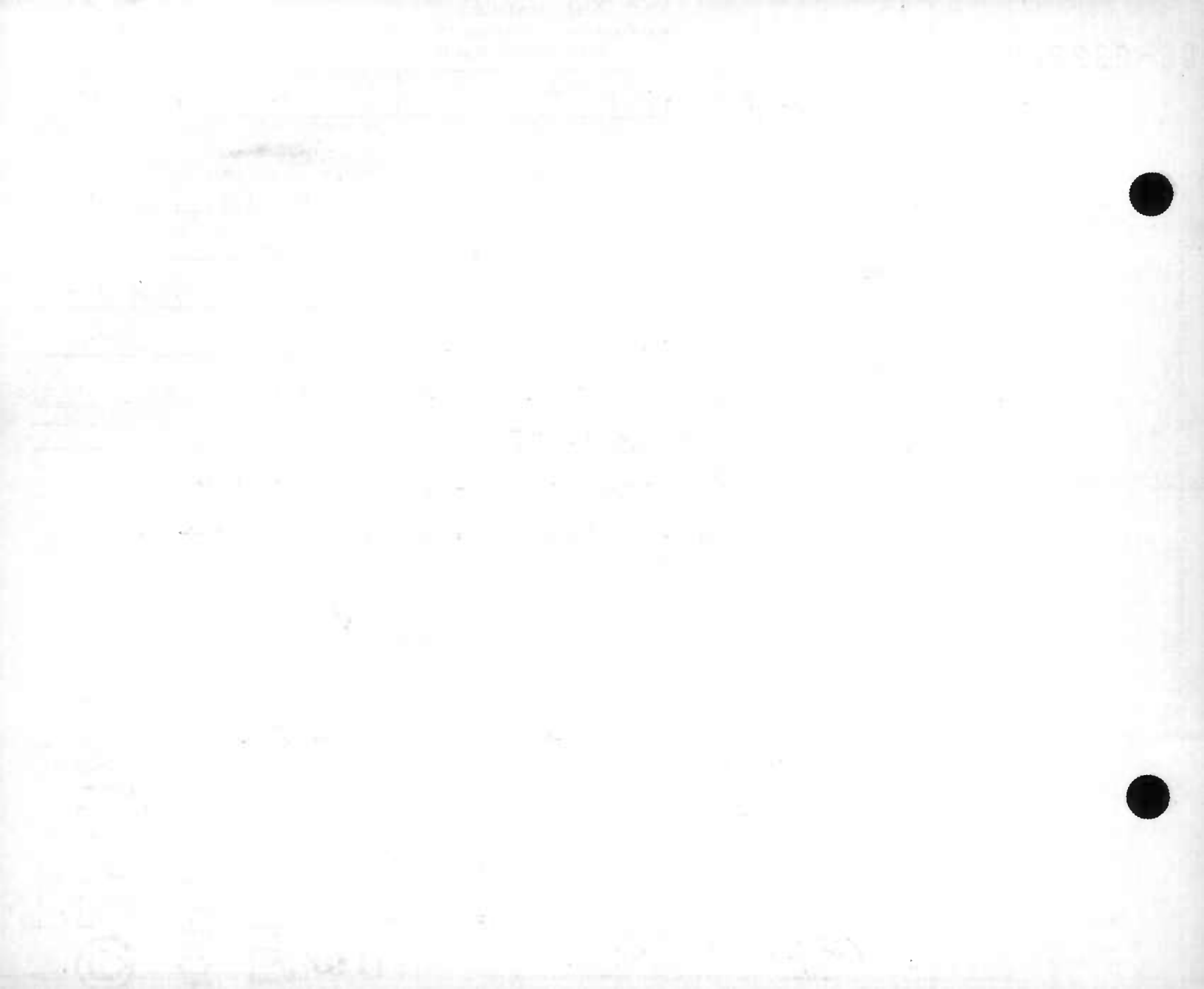
FOR
1- STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8611475
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) GERTRUDE M. O'HARA		2a. DATE OF DEATH MONTH DAY YEAR 4-6-86		2b. HOUR 1059 M	
3. SEX Female	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR 07/12/13		6. AGE (IN YEARS LAST BIRTHDAY) 72	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NY		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10. CITY OR TOWN OF DEATH Elkton		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Union Hosp of Cecil County		9. BALTIMORE CITY OR COUNTY OF DEATH Cecil County MD.	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Home maker					
12b. KIND OF BUSINESS OR INDUSTRY					
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a. STATE MD	13b. COUNTY Cecil	13c. CITY OR TOWN Elkton	13d. INSIDE CITY LIMITS YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS 219 Appleton Acres Ct	
14. FATHER'S NAME FIRST MIDDLE LAST WILLIAM		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARY KENNEY			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 096 03 7407		17. INFORMANT ADDRESS Patrick O'Hara, 25 Appleton Court, Elkton, Md	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ARREST DUE TO, OR AS A CONSEQUENCE OF (b) END STAGE HEART FAILURE, CORONARY OCCLUSION DUE TO, OR AS A CONSEQUENCE OF (c) thrombotic heart disease, coronary artery disease				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 1980 , 19____, to 4/6/86 , 19____, that (I) (we) last saw the deceased alive on 4-5-86 , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Dr. Phillip Pollner		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 4-6-86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Phillip Pollner		22e. ADDRESS 131 W. Main St., Elkton, Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Apr. 10, 1986		23c. NAME OF CEMETERY OR CREMATORY Immaculate Conception	
23d. LOCATION CITY OR TOWN COUNTY STATE Elkton Cecil Md.		23e. DATE REC'D. BY REGISTRAR APR 11 1986		23f. REGISTRAR'S SIGNATURE John Anderson	
24. FUNERAL DIRECTOR NAME Reesh E. Hicks		25. DATE REC'D. BY REGISTRAR APR 11 1986			
HICKS HOME FOR FUNERALS ELKTON, MD.					

BP

DHMH-16 20M
(VRA 15, 4) 7/78



0-06037

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then place remains in the casket, and return to the funeral home. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of cause.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Roberts I. ORNDORF</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>4/29/86</i>		2b. HOUR <i>16:20PM</i>				
3. SEX <i>F</i>		4. RACE <i>white</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>10-24-1915</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>70</i>			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Phila. Pa.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Cecil County - RAISING SUN, MD.</i>			
10. CITY OR TOWN OF DEATH <i>Rising Sun</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>38 Ponce Circle Rising Sun</i>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>housewife</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>home</i>		
13a. STATE <i>md</i>		13b. COUNTY <i>Cecil</i>		13c. CITY OR TOWN <i>Rising Sun</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <i>38 Ponce Circle 21911</i>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>Robert Engersoll</i>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>MARY "NA"</i>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>			16b. SOCIAL SECURITY NO. <i>160 097789</i>		17. INFORMANT <i>Frederick Orndorff</i>			ADDRESS <i>Rising Sun md 38 Ponce Circle 21911</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardio Respiratory arrest</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Terminal Cancer of B. Bladder.</i> DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION <i>12/23/75</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Cancer of B. Bladder.</i>			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>Jose R. Monasterio MD</i>				DEGREE <i>MD</i>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>4/29/86</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Jose R. Monasterio MD</i>				22e. ADDRESS <i>Med. Bldg #205 - WEST GROVE PARK 372</i>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>BURIAL</i>		23b. DATE <i>May 3, 1986</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Little Britain Presby Ch. Peach Bottom Lancaster Pa.</i>		23d. LOCATION CITY OR TOWN COUNTY STATE			
24. FUNERAL DIRECTOR <i>Earl Reynolds Jr. Essexville Pa.</i>									

BP _____



00-05580

Film G615 item 18

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

11477

1. FOR STATE REGISTRAR 5/27/86 rja		2a. DATE KNOWN OF DEATH MAY 4 30 1986		2b. HOUR M
3. RELEASED NAME (TYPE OR PRINT) FIRST: EARL A. MIDDLE: PETERSEN LAST: PETERSEN		2c. DATE PRONOUNCED DEAD MAY 4 30 1986		2d. HOUR P M 8:16
1. SEX Male	4. RACE White	5. DATE OF BIRTH 7-24-1926	6. AGE (IN YEARS) 59 YRS.	7. IF UNDER 1 YR. MONTHS: DAYS: HOURS: MIN:
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) S.D.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
9. BALTIMORE CITY OR COUNTY OF DEATH Cecil County		10. CITY OR TOWN OF DEATH Elkton		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Union Hospital
12a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.		13b. COUNTY Cecil		13c. CITY OR TOWN North East
14. FATHER'S NAME Hiram Barton		15. MOTHER'S MAIDEN NAME Claara Felix		16. SOCIAL SECURITY NO. 504-26-3437
17. INFORMANT Dana J. Petersen Perryville, Md.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple injuries DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)		19. PROBABLE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). Arteriosclerotic Cardiovascular Disease				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR: MIN: MONTH: DAY: YEAR: 7:45 P.M. 4-30- 1986		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Driver of pick-up truck that lost control.
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) road		21f. LOCATION STREET: CITY OR TOWN: COUNTY: STATE: Rt. 40 near Marley Rd., North East, Cecil, MD
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .				
ACTUAL SIGNATURE Dennis F. Smyth, M.D.		TITLE (SPECIFY) Assistant		DATE SIGNED 5-1-86
EXAMINER'S NAME (TYPE OR PRINT) Dennis F. Smyth, M.D.		ADDRESS 111 Penn St., Balto., MD 21201		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5-3-86		23c. NAME OF CEMETERY OR CREMATORY North East Mth Co.
24. FUNERAL HOME NAME Robert T. Crouch		ADDRESS North East Cecil Md.		25. DATE REC'D. BY REGISTRAR MAY 5 1986
26. REGISTRAR'S SIGNATURE John		27. REGISTRAR'S SIGNATURE John		

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (1))
20M 4/82

DAVID

10-10-10

00-03851

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DMMH - 17
(VR A15 ME (1))
20M 4/82

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 11478
1. DECEASED NAME (TYPE OR PRINT)		FIRST Eula		MIDDLE D.		LAST Price		2a. DATE KNOWN OF DEATH ESTIMATED		2b. HOUR
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR DEC. 11. 1928		6. AGE (IN YEARS) (LAST BIRTHDAY) 57 YRS.	IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 4 11 19 86		2d. HOUR 855A	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) North Carolina		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Cecil County				
10. CITY OR TOWN OF DEATH Elkton		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 404 Tony's Rd				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Tube Roller		12b. KIND OF BUSINESS OR INDUSTRY N.V.F. Co.		
13a. STATE Maryland		13b. COUNTY Cecil		13c. CITY OR TOWN Elkton		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 404 Tony's Road		21921
14. FATHER'S NAME FIRST MIDDLE LAST Dave - Price				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lizzie - Mahala						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 219-30-5266		17. INFORMANT ADDRESS Mrs. Zella P. Price, Elkton, Md. 21921				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Atherosclerotic heart disease</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1										
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/> .										
ACTUAL SIGNATURE <i>Juan C. Gonzalez-Vitale</i>				TITLE (SPECIFY) M.D. Deputy				DATE SIGNED 4-11-86		
EXAMINER'S NAME (TYPE OR PRINT) Juan C Gonzalez-Vitale MD				ADDRESS Union Hospital Elkton MD 21921						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 4-14-86		23c. NAME OF CEMETERY OR CREMATORY Church of Christ Cemetery, Elkton, Md.				23d. LOCATION CITY OR TOWN COUNTY STATE		
24. FUNERAL DIRECTOR NAME HICKS HOME for FUNERALS, ELKTON, MD. 21921				25a. DATE REC'D. BY REGISTRAR APR 17 1986				25b. REGISTRAR'S SIGNATURE <i>Juan C. Gonzalez-Vitale</i>		

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11-11-1950

North Carolina

USA

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

00-04176

FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8611479
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST WALLACE G. RUSSELL			2a. DATE OF DEATH MONTH DAY YEAR APRIL 17, 1986			2b. HOUR 6:50P M	
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR SEPTEMBER 13, 1917		6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS 68 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PA		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH CECIL MD.	
10. CITY OR TOWN OF DEATH PERRY POINT, MD		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) VA MEDICAL CENTER		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) (RET) MAINTENANCE		12b. KIND OF BUSINESS OR INDUSTRY FED GOVT EDGEWOOD	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. COUNTY 13c. CITY OR TOWN MD HARFORD HAVRE de GRACE				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 353 WILSON STREET 21078	
14. FATHER'S NAME FIRST MIDDLE LAST WALLACE GOLDSBORO RUSSELL, SR				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST HELEN HEISLER			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW II 181-10-6842		17. INFORMANT ADDRESS MRS OOROTHY R. RUSSELL SAME AS #13e			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CANCER OF ESOPHAGUS WITH METASTASIS DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. }							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (x) (this hospital) attended the deceased from APRIL 4 , 19 86 , to APRIL 17 , 19 86 , that (we) (we) lost saw the deceased alive on APRIL 17 , 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. I (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Mahmut N. Atay, M.D.</i>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MAHMUT N. ATAY, M.D.				22e. ADDRESS VA MEDICAL CENTER, PERRY POINT, MD.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 19APRIL86		23c. NAME OF CEMETERY OR CREMATORY HARFORD MEMORIAL GAROENS		23d. LOCATION CITY OR TOWN COUNTY STATE ALDINO, HARFORD CO., MARYLAND	
24. FUNERAL DIRECTOR NAME ADDRESS MITCHELL FUNERAL HOME, HAVRE DE GRACE, MD.				25a. DATE REC'D. BY REGISTRAR APR 21 1986		25b. REGISTRAR'S SIGNATURE <i>John Anderson</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be mailed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

00-0116

515

NOTICE OF

WILLIAM T. J. J.

APR 21 1980

00-05232

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8 6 1 1 4 8 0
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Jettie Marie Shelton			2a. DATE OF DEATH MONTH DAY YEAR 4/27/86		2b. HOUR 1635 M			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Feb. 5, 1938		6. AGE (IN YEARS LAST BIRTHDAY) 48 YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Raven, Va.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Cecil Co MD		
10. CITY OR TOWN OF DEATH EIK TON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Union Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY ---	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland		13b. COUNTY Harford		13c. CITY OR TOWN Bel Air		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST Dewey --- Hunt		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Della --- Smith		13e. STREET ADDRESS / ZIP CODE 3134 Nova Scotia Road 21014				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) ---		17. INFORMANT ADDRESS Bel Air, Md. 21014 Harold C. Shelton, 3134 Nova Scotia Road				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiorespiratory arrest DUE TO, OR AS A CONSEQUENCE OF (b) Coc pulmonary DUE TO, OR AS A CONSEQUENCE OF (c) Severe bullous emphysema APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (1) (this hospital) attended the deceased from 3-2 , 19 86 , to 4-27 , 19 86 , that (1) (we) last saw the deceased alive on 4-24 , 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (2) (we) (did) (did not) view the body after death.								
22b. SIGNATURE Richard H. KART		DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 4-28-86		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Richard H. KART M.D.		22e. ADDRESS EIK TON Md 21921						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE April 30, 1986		23c. NAME OF CEMETERY OR CREMATORY St. Paul's Lutheran Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Aberdeen Harford Md.		
24. FUNERAL DIRECTOR NAME ADDRESS Howard K. McComas III, Abingdon, Md. 21009				25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE APR 30 1986				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called at once.

09 100

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

8611481
REG. NO.1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) KENNETH L. THOMAS			2a. DATE OF DEATH MONTH DAY YEAR April 11, 1986			2b. HOUR 10:20am					
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR JUNE 12 1934		6. AGE (IN YEARS LAST BIRTHDAY) 51 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH CECIL COUNTY MD.					
10. CITY OR TOWN OF DEATH Perry Point, Md.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) VA Medical Center				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SELF-EMPLOYED		12b. KIND OF BUSINESS OR INDUSTRY ELECTRICIAN			
13a. STATE MD.			13b. COUNTY -		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 2328 WASHINGTON BLVD. 21230		
14. FATHER'S NAME FIRST MIDDLE LAST WILLIAM J. THOMAS			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARGARET KILMAN			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES				16b. SOCIAL SECURITY NO. 12-56 11-57 218-28-9792	
17. INFORMANT ADDRESS SALLY THOMAS (sister-in-law) 4047 SINCLAIR LANE			17. INFORMANT ADDRESS 21213			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiopulmonary arrest DUE TO, OR AS A CONSEQUENCE OF (b) Pneumonia DUE TO, OR AS A CONSEQUENCE OF (c) 10 days				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 days	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Dementia of the Alzheimers Type, Schizophrenia, Central Dysphasia											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPT? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from September 23, 1983 to April 11, 1986 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.											
22b. SIGNATURE <i>John Lonergan</i>						DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 4-11-86			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JOHN LONERGAN, M.D.						22e. ADDRESS VA Medical Center, Perry Point, Md.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 4/14/86		23c. NAME OF CEMETERY OR CREMATORY MT. OLIVET CEM.		23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MD.		23e. DATE REC'D. BY REGISTRAR APR 15 1986		
24. FUNERAL DIRECTOR NAME Schittunek Funeral Home, Baltimore, Md.						25b. REGISTRAR'S SIGNATURE <i>Michael Anderson</i>					

0-03642

10:20AM April 11, 1952 R. [illegible]

RECEIVED
OFFICE OF THE
DIRECTOR OF
THE BUREAU OF
THE ARMY
AND
NAVY



10:20AM April 11, 1952 R. [illegible]

10:20AM April 11, 1952 R. [illegible]

10:20AM April 11, 1952 R. [illegible]

Amos Trimble - Cecil Co. 4-26-86

✓ ID DEATH CERTIF. #

86-11482

SEE MAY, 1986 DEATHS



00-05351

**STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

REG. NO. 1483

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (LAST, FIRST, MIDDLE) BILLIE D. WEBB		2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> ESTIMATED <input type="checkbox"/> 4-21-86		2b. HOUR 4:05 A.M.
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR JUNE 5, 1933	6. AGE (IN YEARS LAST BIRTHDAY) 52 YRS.	7. DATE PRONOUNCED DEAD MONTH DAY YEAR 4-21-86
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
9. CITY OR TOWN OF DEATH Elkton		10. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN STATE HEALTH DEPARTMENT STREET ADDRESS) Union Hospital		
11. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland		13b. CITY OR TOWN Cecil		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Frank Webb		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ella Stone		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. 1953-55 232-52-3649		17. INFORMANT ADDRESS Mrs. Shirley G. Webb, Elkton, Md. 21921
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia and chronic pancreatitis DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22. I certify that I took charge of the remains described herein (BODY ONLY) Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>				
ACTUAL SIGNATURE <i>Margarita A. Korell</i>		TITLE (SPECIFY) Assistant		DATE 4-21-86
EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Korell, M.D.		ADDRESS 111 Penn Street		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 4-24-86	23c. NAME OF CEMETERY OR CREMATORY Union Methodist Cemetery	
23d. LOCATION CITY OR TOWN Union		COUNTY Cecil		
23e. STATE Md.		24. FUNERAL DIRECTOR <i>Joseph E. Hicks</i> HICKS HOME for FUNERALS, ELKTON, MD. 21921		
25a. DATE REC'D. BY REGISTRAR MAY 1 1986		25b. REGISTRAR'S SIGNATURE <i>Julia Davidson Randall</i>		

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-1. RETURN PAGE 5 FOR YOUR FILES TO FUNERAL DIRECTOR. PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

BP

DHMH - 17
(VR A15 ME (5))
20M 4/82

Date: June 2, 1953

Post Office

Electrical Commission

Franklin D. Roosevelt

Franklin D. Roosevelt

1953-54 235-22-3449 Mrs. Shirley A. Webb, Lincoln, Neb. 21921

RECEIVED

Union Methodist Community

June 2, 1953, Lincoln, Neb. 21921

00-05505

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8611484
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Elsie E. White			2a. DATE OF DEATH MONTH DAY YEAR April 25, 1986		2b. HOUR 1:10 P.M.						
3 SEX Female		4 RACE White		5. DATE OF BIRTH MONTH DAY YEAR Nov. 18, 1893		6. AGE (IN YEARS LAST BIRTHDAY) 92 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		8. IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New Castle, Del.		7b. CITIZEN OF WHAT COUNTRY? US		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Cecil MD.					
10. CITY OR TOWN OF DEATH Rising Sun		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Calvert Manor Nursing Home, Inc.						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD						13b. COUNTY Cecil		13c. CITY OR TOWN North East		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST August Carlsson						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Augusta Dennison					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) 216-46-0204		17. INFORMANT ADDRESS John White, 16 Rebel Rd., Radnor, PA 19087							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary heart failure.</u> DUE TO, OR AS A CONSEQUENCE OF: (b) <u>ASCD.</u> DUE TO, OR AS A CONSEQUENCE OF: (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (1) the hospital attended the deceased from _____, 19_____, to _____, 19_____, that (2) we last saw the deceased alive on <u>4/25/86</u> , 19_____, and that in (my) <u>MD</u> opinion death occurred on the date and hour and from the causes stated above (b) (c) (d) (e) (f) (g) (h) (i) (j) (k) (l) (m) (n) (o) (p) (q) (r) (s) (t) (u) (v) (w) (x) (y) (z) (aa) (ab) (ac) (ad) (ae) (af) (ag) (ah) (ai) (aj) (ak) (al) (am) (an) (ao) (ap) (aq) (ar) (as) (at) (au) (av) (aw) (ax) (ay) (az) (ba) (bb) (bc) (bd) (be) (bf) (bg) (bh) (bi) (bj) (bk) (bl) (bm) (bn) (bo) (bp) (bq) (br) (bs) (bt) (bu) (bv) (bw) (bx) (by) (bz) (ca) (cb) (cc) (cd) (ce) (cf) (cg) (ch) (ci) (cj) (ck) (cl) (cm) (cn) (co) (cp) (cq) (cr) (cs) (ct) (cu) (cv) (cw) (cx) (cy) (cz) (da) (db) (dc) (dd) (de) (df) (dg) (dh) (di) (dj) (dk) (dl) (dm) (dn) (do) (dp) (dq) (dr) (ds) (dt) (du) (dv) (dw) (dx) (dy) (dz) (ea) (eb) (ec) (ed) (ee) (ef) (eg) (eh) (ei) (ej) (ek) (el) (em) (en) (eo) (ep) (eq) (er) (es) (et) (eu) (ev) (ew) (ex) (ey) (ez) (fa) (fb) (fc) (fd) (fe) (ff) (fg) (fh) (fi) (fj) (fk) (fl) (fm) (fn) (fo) (fp) (fq) (fr) (fs) (ft) (fu) (fv) (fw) (fx) (fy) (fz) (ga) (gb) (gc) (gd) (ge) (gf) (gg) (gh) (gi) (gj) (gk) (gl) (gm) (gn) (go) (gp) (gq) (gr) (gs) (gt) (gu) (gv) (gw) (gx) (gy) (gz) (ha) (hb) (hc) (hd) (he) (hf) (hg) (hh) (hi) (hj) (hk) (hl) (hm) (hn) (ho) (hp) (hq) (hr) (hs) (ht) (hu) (hv) (hw) (hx) (hy) (hz) (ia) (ib) (ic) (id) (ie) (if) (ig) (ih) (ii) (ij) (ik) (il) (im) (in) (io) (ip) (iq) (ir) (is) (it) (iu) (iv) (iw) (ix) (iy) (iz) (ja) (jb) (jc) (jd) (je) (jf) (jg) (jh) (ji) (jj) (jk) (jl) (jm) (jn) (jo) (jp) (jq) (jr) (js) (jt) (ju) (jv) (jw) (jx) (jy) (jz) (ka) (kb) (kc) (kd) (ke) (kf) (kg) (kh) (ki) (kj) (kk) (kl) (km) (kn) (ko) (kp) (kq) (kr) (ks) (kt) (ku) (kv) (kw) (kx) (ky) (kz) (la) (lb) (lc) (ld) (le) (lf) (lg) (lh) (li) (lj) (lk) (ll) (lm) (ln) (lo) (lp) (lq) (lr) (ls) (lt) (lu) (lv) (lw) (lx) (ly) (lz) (ma) (mb) (mc) (md) (me) (mf) (mg) (mh) (mi) (mj) (mk) (ml) (mm) (mn) (mo) (mp) (mq) (mr) (ms) (mt) (mu) (mv) (mw) (mx) (my) (mz) (na) (nb) (nc) (nd) (ne) (nf) (ng) (nh) (ni) (nj) (nk) (nl) (nm) (nn) (no) (np) (nq) (nr) (ns) (nt) (nu) (nv) (nw) (nx) (ny) (nz) (oa) (ob) (oc) (od) (oe) (of) (og) (oh) (oi) (oj) (ok) (ol) (om) (on) (oo) (op) (oq) (or) (os) (ot) (ou) (ov) (ow) (ox) (oy) (oz) (pa) (pb) (pc) (pd) (pe) (pf) (pg) (ph) (pi) (pj) (pk) (pl) (pm) (pn) (po) (pp) (pq) (pr) (ps) (pt) (pu) (pv) (pw) (px) (py) (pz) (qa) (qb) (qc) (qd) (qe) (qf) (qg) (qh) (qi) (qj) (qk) (ql) (qm) (qn) (qo) (qp) (qq) (qr) (qs) (qt) (qu) (qv) (qw) (qx) (qy) (qz) (ra) (rb) (rc) (rd) (re) (rf) (rg) (rh) (ri) (rj) (rk) (rl) (rm) (rn) (ro) (rp) (rq) (rr) (rs) (rt) (ru) (rv) (rw) (rx) (ry) (rz) (sa) (sb) (sc) (sd) (se) (sf) (sg) (sh) (si) (sj) (sk) (sl) (sm) (sn) (so) (sp) (sq) (sr) (ss) (st) (su) (sv) (sw) (sx) (sy) (sz) (ta) (tb) (tc) (td) (te) (tf) (tg) (th) (ti) (tj) (tk) (tl) (tm) (tn) (to) (tp) (tq) (tr) (ts) (tt) (tu) (tv) (tw) (tx) (ty) (tz) (ua) (ub) (uc) (ud) (ue) (uf) (ug) (uh) (ui) (uj) (uk) (ul) (um) (un) (uo) (up) (uq) (ur) (us) (ut) (uu) (uv) (uw) (ux) (uy) (uz) (va) (vb) (vc) (vd) (ve) (vf) (vg) (vh) (vi) (vj) (vk) (vl) (vm) (vn) (vo) (vp) (vq) (vr) (vs) (vt) (vu) (vv) (vw) (vx) (vy) (vz) (wa) (wb) (wc) (wd) (we) (wf) (wg) (wh) (wi) (wj) (wk) (wl) (wm) (wn) (wo) (wp) (wq) (wr) (ws) (wt) (wu) (wv) (ww) (wx) (wy) (wz) (xa) (xb) (xc) (xd) (xe) (xf) (xg) (xh) (xi) (xj) (xk) (xl) (xm) (xn) (xo) (xp) (xq) (xr) (xs) (xt) (xu) (xv) (xw) (xx) (xy) (xz) (ya) (yb) (yc) (yd) (ye) (yf) (yg) (yh) (yi) (yj) (yk) (yl) (ym) (yn) (yo) (yp) (yq) (yr) (ys) (yt) (yu) (yv) (yw) (yx) (yy) (yz) (za) (zb) (zc) (zd) (ze) (zf) (zg) (zh) (zi) (zj) (zk) (zl) (zm) (zn) (zo) (zp) (zq) (zr) (zs) (zt) (zu) (zv) (zw) (zx) (zy) (zz)											
22b. SIGNATURE <u>Robert L. Gray</u>		22c. DATE SIGNED 4/26/86		22d. PHYSICIAN'S NAME (TYPE OR PRINT) ROBERT L. Gray							
22e. ADDRESS 717 Bridge St Elkton Md.		22f. DEGREE MD. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5-1-86		23c. NAME OF CEMETERY OR CREMATORY North East Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE North East Cecil Md.					
24. FUNERAL DIRECTOR NAME <u>See Funeral Home</u>		24b. ADDRESS Elkton, Md.		25a. DATE REC'D. BY REGISTRAR MAY 02 1986		25b. REGISTRAR'S SIGNATURE <u>John Landon-Rodriguez</u>					

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies of pages 1 and 2 and should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP _____

Q382 NOTED 2003

QND 11/11/11



00-05703

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

O HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be signed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper pages 1 and 2 and should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
 IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical officer must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
		Frances B. Wollaston				April 29, 1986		7:00 A M	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY) YRS.		IF UNDER 1 YEAR MONTHS DAYS	
Female		White		Sept., 22, 1905		80			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		MD	
Maryland		U.S.				Cecil			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Rising Sun		Calvert Manor Nursing Home, Inc.		Housewife					
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE	
Delaware		New Castle		New3ark				341 S. College Ave. 99999	
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO		17. INFORMANT ADDRESS	
Milton Crew		Hettie Hadaway		No		185-44-0950		Charles Wollaston, 432 Arbour Drive, Newark Del. 19713	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac failure</u>									
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Chronic congestive failure</u>									
DUE TO, OR AS A CONSEQUENCE OF (c) <u>coronary artery disease</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u></u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>2/21</u> , 19 <u>77</u> to <u>4/29</u> , 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>4/28</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE		DEGREE		22c. DATE SIGNED					
James R. Dearworth M.D.				4/30/86					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>					
James R. Dearworth M.D.		167 W. Mainst. Newark, De.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
Burial		5/1/86		Graeelawn Mem. Pk.		Farnhurst N.C. De.			
24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
Hicks Home For Funerals, EIKTON, MD		MAY 06 1986		John D. ...					

00-02703

